

## CERTIFICATE OF DEATH

Reg. Dist. No.

8593

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |   | c. LENGTH OF STAY IN 1b<br><b>4 Days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLEN</b> Middle <b>M.</b> Last <b>ALLEN</b>  |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>9</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-20-93</b>                                       |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.   |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13. FATHER'S NAME<br><b>JOHN LEGGE (D)</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>NANCY BEAL (D)</b>   |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   | 17. INFORMANT<br><b>CHART</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO <b>Pyelonephritis, chronic, severe</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b><br>(c) <b>hypertensive and atherosclerotic Cardio-Vascular Disease</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b><br><b>unknown</b><br><b>unknown</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertensive and atherosclerotic Cardio-Vascular Disease</b>   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACQUEDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>NO</b>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>STC = abscess, left atria</b>                         |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>May 59</b> to <b>August 9 1959</b> , that I last saw the deceased alive on <b>Aug 8</b> , 19 <b>59</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.  |   | ADDRESS (Street, city or town, state) <b>59 GREENE ST. M CUMBERLAND, MD.</b>   |  |
| ACTUAL SIGNATURE <b>Byron Kight</b>   |   | DATE SIGNED <b>Aug 9, 1959</b>   |  |
| PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Aug. 12, 1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Kight</b>  |   | ADDRESS<br><b>Cumberland, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>AUG 13 59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

1

DATE OF DEATH: AUG. 12, 1953  
PLACE OF DEATH: CHICAGO, ILL.  
CAUSE OF DEATH: HEART DISEASE  
AGE: 78  
SEX: M  
RACE: W  
BIRTH: 1875  
MARRIAGE: 1900  
OCCUPATION: RETIRED  
EDUCATION: HIGH SCHOOL  
RELIGION: METHODIST  
BAPTIST CHURCH  
FAMILY NAME: [illegible]  
MOTHER'S NAME: [illegible]  
FATHER'S NAME: [illegible]  
BORN: [illegible]  
DIED: [illegible]  
BURIED: [illegible]  
CITY: [illegible]  
STATE: [illegible]  
COUNTRY: [illegible]

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08568

Reg. Dist. No.

8594

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>02</b> <b>Cumberland</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>342 Baltimore Ave.</b>  |                                  | d. STREET ADDRESS<br><b>342 Baltimore Ave</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Howard</b> Middle <b>Wayne</b> Last <b>Arnold</b>  |                                  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>29</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 5, 1901</b> |
| 9. AGE (In years last birthday)<br><b>57</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Tree Surgeon</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Forestry</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Thomas, W. Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Lewis W. Arnold</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>XXXXXX Mary Hebb</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>220-10-8748</b>   |   |
| 17. INFORMANT<br><b>Mrs. Howard Arnold</b>   |                                  | Address<br><b>342 Baltimore Ave.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the bladder</b><br><b>181.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>8-10</b> , 19 <b>59</b> , to <b>8-29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-20</b> , 19 <b>59</b> , and that death occurred at <b>2:20 A.M.</b> from the causes and on the date stated above.  |                                  | ADDRESS (Street, city or town, state) DATE SIGNED <b>8-30-59</b>  |   |
| ACTUAL SIGNATURE <b>Lewis Brings</b> M.D.  |                                  |   |   |
| PHYSICIAN'S NAME (Type) <b>Lewis Brings M. D.</b>  |                                  | <b>57 Greene St. Cumberland, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 31, 1959</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Davis, W. Va.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George, Cumberland, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>SEP 1 1959</b>  |   |
|  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles L. George</b>  |   |

# CERTIFICATE OF DEATH

348

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1950

|   |  |
|---|--|
| <p>1. Name of deceased: _____</p>       |  |
| <p>2. Sex: _____</p>                    |  |
| <p>3. Date of birth: _____</p>          |  |
| <p>4. Place of birth: _____</p>         |  |
| <p>5. Date of death: _____</p>          |  |
| <p>6. Place of death: _____</p>         |  |
| <p>7. Cause of death: _____</p>         |  |
| <p>8. Signature of physician: _____</p> |  |
| <p>9. Signature of registrar: _____</p> |  |
| <p>10. Date of registration: _____</p>  |  |

8595  
CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b <b>4/13/59</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>   |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>   |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | d. STREET ADDRESS <b>214 E. Main Street</b>  |   |
| 3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Arnone</b> Last <b>Arnone</b>  |                                  | 4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1959</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/13/1866</b>                                   |
| 9. AGE (In years last birthday) <b>93</b> yrs.  |                                  | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS. Months Days Hours Min.                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Fruit Store Proprietor</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Italy</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Italy</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |   |
| 13. FATHER'S NAME <b>Frank Arnone</b>   |                                  | 14. MOTHER'S MAIDEN NAME <b>Carmel Sicoli</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>   |                                  | <b>Allegany County Infirmary Records</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b><br>422.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis.</b><br>DUE TO (c) <b>Senile Deterioration</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Nephritis</b> |                                  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH ?  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>4/13/59</b> , 19____, to <b>8/7/59</b> , 19____, that I last saw the deceased alive on <b>8/6/59</b> , 19____, and that death occurred at <b>5:50A</b> M, from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |                                  | ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>8/7/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>  |                                  | <b>Cumberland, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 22b. DATE THEREOF <b>8-10-59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>   | 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst</b>   |                                  | ADDRESS <b>Frostburg, Md.</b>  |   |
| 24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>  |   |

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TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Allegany

Allegany

Woodbury

Edw. S. Main Street

Allegany

Allegany

Allegany

Allegany

Allegany County

Allegany, Md.

Allegany, Md.

Allegany

Allegany, Maryland

Allegany, Md.



8596

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>9 DAYS</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give place of death) OR INSTITUTION<br><b>WARWICK &amp; MEMORIAL HOSPITAL</b>   |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MADELINE</b> Middle <b>Q</b> Last <b>BIDDLE</b>  |                                     | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>27</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPTEMBER 13, 1897</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager- ladies wear department.</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CUMBERLAND, MARYLAND</b>   | 9. AGE (In years last birthday) <b>61</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 13. FATHER'S NAME<br><b>DAVID BIDDLE</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>REBECCA HARTSOCK</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.<br><b>214-05-8174</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>151x</b> DUE TO <b>Acute Carcinoma to Metastatic Lesions.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/4 yrs.</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 27</b> , 19 <b>59</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>133 VIRGINIA AVENUE, CUMBERLAND, MD.</b>  |                                     |  |   |
| ACTUAL SIGNATURE<br><b>Dr. Overton</b>   |                                     | DATE SIGNED<br><b>8/28/59</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>DR. OVERTON, HIMMELWRIGHT</b>  |                                     | <b>133 VIRGINIA AVENUE, CUMBERLAND, MD.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>8/29/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Park</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Rt 3 Maryland</b>      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b>  |                                     | ADDRESS<br><b>Cumberland Maryland</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 31 '59</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Hume</b>  |   |

1

Page 4

death.

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

00370

CERTIFICATE OF DEATH

00370

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8597

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b><br>b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |   | c. LENGTH OF STAY IN 1b<br><b>15 DAYS</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>825 SHAWNEE AVENUE</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>FRANCIS</b> Middle <b>RAY</b> Last <b>BLOSE</b>  |   | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>8</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUGUST 13, 1904</b>   |
| 9. AGE (In years lost birthday)<br><b>54</b> yrs.   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Vice President</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>1st Nat'l Bank</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA Trade City U. S. A.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>FRED CARLTON BLOSE</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Matilda Alabran</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |   | 16. SOCIAL SECURITY NO.<br><b>171-12-8942</b>   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>525X</b> DUE TO <b>Congestive Heart failure (rt)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis, Emphysema</b> DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>One wk.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>7-13-59</b> to <b>8-8-59</b> , that I last saw the deceased alive on <b>8-8-59</b> , and that death occurred at <b>3:40</b> , from the causes and on the date stated above.  |   |   |  |
| ACTUAL SIGNATURE<br><b>W. F. Williams</b> M.D.  |   | ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>8-10-59</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. W. F. WILLIAMS</b>  |   | <b>122 So. Centre St. Cumberland, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>Aug. 11, 1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rural Valley Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Rural Valley, Pennsylvania</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 14 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kraus</b>   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
EDUCATION  
MARRIAGE  
RELIGION  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER  
SIGNATURE OF CLERGYMAN  
SIGNATURE OF JUDGE  
SIGNATURE OF SHERIFF  
SIGNATURE OF CORONER  
SIGNATURE OF DISTRICT ATTORNEY  
SIGNATURE OF COUNTY CLERK  
SIGNATURE OF TOWN CLERK  
SIGNATURE OF VILLAGE CLERK  
SIGNATURE OF CITY CLERK  
SIGNATURE OF COUNTY RECORDER  
SIGNATURE OF TOWN RECORDER  
SIGNATURE OF VILLAGE RECORDER  
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SIGNATURE OF TOWN CLERK  
SIGNATURE OF VILLAGE CLERK  
SIGNATURE OF CITY CLERK  
SIGNATURE OF COUNTY RECORDER  
SIGNATURE OF TOWN RECORDER  
SIGNATURE OF VILLAGE RECORDER  
SIGNATURE OF CITY RECORDER

REPORT OF PHYSICIAN  
REPORT OF NURSE  
REPORT OF CLERGYMAN  
REPORT OF JUDGE  
REPORT OF SHERIFF  
REPORT OF CORONER  
REPORT OF DISTRICT ATTORNEY  
REPORT OF COUNTY CLERK  
REPORT OF TOWN CLERK  
REPORT OF VILLAGE CLERK  
REPORT OF CITY CLERK  
REPORT OF COUNTY RECORDER  
REPORT OF TOWN RECORDER  
REPORT OF VILLAGE RECORDER  
REPORT OF CITY RECORDER  
REPORT OF COUNTY CLERK  
REPORT OF TOWN CLERK  
REPORT OF VILLAGE CLERK  
REPORT OF CITY CLERK  
REPORT OF COUNTY RECORDER  
REPORT OF TOWN RECORDER  
REPORT OF VILLAGE RECORDER  
REPORT OF CITY RECORDER

.8598

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART</b>  |  |   |  | d. STREET ADDRESS<br><b>89 GREEN ST.</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LEONA</b> Middle <b>SUSAN</b> Last <b>BRANT</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>3</b> Year <b>19 59</b>  |  |   |   |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>                                      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-17-1898</b>   |   |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>3</b> Hours <b>19</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>8</b> Days <b>3</b> Hours <b>19</b> Min.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Domestic Work</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Y.M.C.A.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND, Cumberland</b>                          |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |   |   |
| 13. FATHER'S NAME<br><b>WILLIAM KENNEDY (D)</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ADA KENNEDY</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>213-22-4037</b>  |  |   |   |
| 17. INFORMANT<br><b>CHART.</b>   |  |   |  | Address  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro intestinal Hemorrhage</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Possible neoplasm Stomach - ?</b><br>DUE TO<br>(c)                  |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Arteriosclerotic Heart Disease with Coronary Fibillation</b>   |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |   |
| 20f. (City or town)<br><b>Cumberland</b>   |  |   |  | (County)   |  | (State)   |   |
| 21. I certify that I attended the deceased from <b>8-1</b> , 19 <b>59</b> , to <b>8-3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-3</b> , 19 <b>59</b> , and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>401 N Center St</b> DATE SIGNED <b>8-3-59</b> |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE <b>William P James</b>  |  |   |  | M.D. <b>401 N Center St</b>  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>William P James</b>   |  |   |  | <b>Cumberland, Md</b>  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8-5-59</b>                                    |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>William P James</b>  |   |

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8137

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

11-17-11

WILLIAM H. HARRIS

THE DEPT. OF HEALTH

CHIEF

8599

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>2/14/1957</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Home</b>   |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Francis</b> Last <b>Breighner</b>   |                                     | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>26</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>10/10/1877</b>  |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min.                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - B. &amp; O. Machinist/ Rwy.</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland Emmittsburg, U. S. A.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S. A.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Joseph I. Breighner</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Annie Baker</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No,</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>705-05-4787</b>   |  |
| 17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b>  |                                     | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>420.1 DUE TO <b>Chronic Myocardial Degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b><br>(c) <b>Chronic Hepatitis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Hepatitis</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>2/14/57</b> 19 to <b>8/26/59</b> 19, that I last saw the deceased alive on <b>8/25/59</b> 19, and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above. |                                     | ADDRESS (Street, city or town, state) DATE SIGNED   |  |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |                                     | <b>49 Greene St. 8/26/59</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>  |                                     | <b>Cumberland, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8/29/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>  |                                     | ADDRESS<br><b>Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 31 '59</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Clinton S. Thomas</b>  |  |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician. The attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

Reg. No. 114

Age 54

Married

White

Male

Commonwealth

State of Maryland

County of Baltimore

1850-1855

1855-1860

1860-1865

Age 54

Married

White

Male

51

1865-1870

1870-1875

1875-1880

Residence - 1111 North Avenue, U. S. A.

Residence - 1111 North Avenue, U. S. A.

John E. Baker

John E. Baker

1111 North Avenue, U. S. A.

1111 North Avenue, U. S. A.

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1111 North Avenue, U. S. A.



8652

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Barton</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>25 Yrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nannie</b> Middle <b>Catherine</b> Last <b>Brown</b>   |                                    | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>29</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 24, 1899</b>                          |
| 9. AGE (In years lost birthday)<br><b>60</b> yrs.  |                                    | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Barton, Md.</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>George Davis</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Annie Wilson</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                    | 16. SOCIAL SECURITY NO.<br><b>Edison Davis</b> Address <b>Barton, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis</b> DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>5 yrs</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>54</b> to <b>Aug 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>aug 29</b> , 19 <b>59</b> , and that death occurred at <b>9 P.</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Piedmont W. Va</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>P. E. Berry</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>P. E. BERRY</b>   |                                    |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9/3/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. L. Breal</b>   |                                    | ADDRESS<br><b>Westernport, Md.</b>  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 3 '59</b>                   |
|  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Knaak</b>  |  |

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

152-9

STATE OF NEW YORK

CERTIFICATE OF DEATH

3573

Blank form with faint horizontal lines and vertical columns for data entry.

8600

## CERTIFICATE OF DEATH

08575

Reg. Dist. No.

|  |                                  |   |  |   |  |  |   |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b<br><b>years</b>   |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>35 South Street</b>   |                                  |   |  | d. STREET ADDRESS<br><b>35 South Street</b>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>BENJAMIN</b> Last <b>BURNER</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>4</b> Year <b>1959</b>   |  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 5, 1880</b>  |   | 9. AGE (In years last birthday)<br><b>78</b> yrs.                      |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Boiler Mkr.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. Railroad</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Woodstock, Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>John Burner</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Kidler</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>705-09-7896</b>   |  | 17. INFORMANT<br><b>Mrs. Marvin Campbell</b> <b>35 South Street</b><br><b>Cumberland, Maryland</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hr.</b><br><b>10 yrs -</b>                        |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |   |
| 20f. (City or town) (County) (State)   |                                  |   | 21. I certify that I attended the deceased from <b>June 2, 1957</b> to <b>Aug. 4, 1959</b> , that I last saw the deceased alive on <b>Aug. 1, 1959</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above. |   |  |  |   |
| ACTUAL SIGNATURE <b>H. W. Eliason</b> M.D.   |                                  |   | ADDRESS (Street, city or town, state) <b>126 Union St. Cumberland, Md</b> DATE SIGNED <b>Aug 8/59</b>  |   |  |  |   |
| PHYSICIAN'S NAME (Type) <b>H. W. Eliason M.D. 126 Union Street, Cumberland, Maryland</b>   |                                  |   |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 7, 1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                 |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 10 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |

Page 4

To be executed within 24 hours.

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8601

## CERTIFICATE OF DEATH

08576

Reg. Dist. No.

|   |                               |  |                                  |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |                               | c. LENGTH OF STAY IN 1b <b>8/4/59</b>  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 3. NAME OF DECEASED (Type or print) <b>Mary Ellen Coffey</b>  |                               | 4. DATE OF DEATH <b>August 10 19 59</b>  |                                  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>1/5/1874</b> |
| 9. AGE (In years last birthday) <b>85</b> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>10</b> Hours <b>10</b> Min.   |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Footer's Cleaning &amp; Dye</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Maryland</b>  |                                  |
| 11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |                                  |
| 13. FATHER'S NAME <b>Patrick Coffey</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Julia Malone</b>   |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>214-05-7122</b>   |                                  |
| 17. INFORMANT <b>P.O. Box 599</b>   |                               | Address <b>Cumberland, Md.</b>   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b><br>592X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b><br>DUE TO (c) <b>Chronic Nephritis</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>  |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary anemia</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that I attended the deceased from <b>8/4/59</b> , 19, to <b>8/10/59</b> , 19, that I last saw the deceased alive on <b>8/10/59</b> , 19, and that death occurred at <b>8:40 P. M.</b> from the causes and on the date stated above.   |                               |  |                                  |
| ACTUAL SIGNATURE <b>James E. McLean</b>   |                               | ADDRESS (Street, city or town, state) <b>49 Greene St.</b>   |                                  |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>  |                               | DATE SIGNED <b>8/11/59</b>   |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>8-13-59</b>   |                                  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick Cem.</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>   |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>  |                               | ADDRESS <b>Cumberland, Md.</b>   |                                  |
| 24a. REC'D BY REGISTRAR <b>DATE AUG 17 '59</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |                                  |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.



CERTIFICATE OF DEATH

|   |  |
|---|--|
| MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  |  |
| Allegany  |  |
| Underlying Cause of Death                             |  |
| Allegany County Infirmity                             |  |
| Date of Death   |  |
| Place of Death  |  |
| Residence - Rooming & Dining & Dry Cleaning, Maryland |  |
| Occupation - Sales                                    |  |
| Age   |  |
| Sex   |  |
| Race  |  |
| Marital Status  |  |
| Education   |  |
| Religion  |  |
| Cause of Death  |  |
| Contributing Causes                                   |  |
| Medical History                                       |  |
| Social History  |  |
| Family History  |  |
| Autopsy   |  |
| Signature of Physician                                |  |
| Signature of Registrar                                |  |
| Date of Registration                                  |  |
| Place of Registration                                 |  |
| Remarks   |  |



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08577

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <span style="float:right">MARYLAND</span>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Allegany</b></span> |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Cumberland</b>  |   | c. LENGTH OF STAY IN 1b<br><b>54 Yrs.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Cumberland</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rt. 5</b>   |   |   | d. STREET ADDRESS<br><b>Rt. 5</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>John Hoffman Collins</b>   |   |   | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>1,</b> Year <b>1959</b>   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 18, 1904</b>   | 9. AGE (In years last birthday)<br><b>54</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Plumbing</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pinto, Maryland</b>   |   |
| 13. FATHER'S NAME<br><b>John H. Collins</b>  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Llewellyn</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>217-10-7729</b>   |  | 17. INFORMANT<br><b>Mrs. Edna Collins</b> Address <b>Rt. 5, Cumberland, Md.</b>                             |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b><br>(c), stating the underlying cause lost. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b><br><br><b>--</b>                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Pinto, Maryland</b>  | (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>       |   |   |  |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED   |   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>  |   | M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  | <b>August 1, 1959</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>8-4-1959</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Pinto Mennonite Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Pinto, Maryland</b>  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>   |   | ADDRESS<br><b>Cumberland, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 5 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

08578

MEDICAL CERTIFICATION

8305

DATE OF DEATH

0557

ALLEGANY

PENNSYLVANIA

CUMBERLAND

3 DAYS

HARRISBURG

WHITEN & MEMORIAL HOSPITAL

157 EAST POPLAR ST.

JAMES

ROBERT

WILLIAM

AUGUST 16

WHITE

JUNE 11, 1958

HONE

HARRISBURG, PA.

ROBERT W. CORRAD

LILLIAN A. CORRAD

HONE

CUMBERLAND, MD. - MEMORIAL HOSPITAL

157 E. POPLAR ST., HARRISBURG, PA.

DR. H. M. ELLISON

Buried Aug. 21, 1959 Valley Forge Cemetery, Harrisburg, Pa.

Berlin, Pa.

Johnson & Son

8603

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND, MD.</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>5 DAYS</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL - WARWICK AVES.</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>C.</b> Last <b>COOK</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>24</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>SEPTEMBER 21, 1886</b>                           |  |
| 9. AGE (In years lost birthday) yrs.<br><b>73</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.                                  |  | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13. FATHER'S NAME<br><b>JOSEPH COOK</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ALICE HALTERMAN</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if unknown) <input type="checkbox"/> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>232-26-1768</b>   |  |   |  |
| 17. INFORMANT<br><b>WARWICK &amp; MEMORIAL AVES CUMBERLAND, MD.</b>  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br><b>450.0</b> DUE TO <b>chronic arteriosclerosis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>chronic arteriosclerosis.</b><br>DUE TO (c) <b>chronic arteriosclerosis.</b> |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>years</b>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                 |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <b>August 17, 1959</b> , to <b>August 24, 1959</b> , that I last saw the deceased alive on <b>August 23, 1959</b> , and that death occurred at <b>12:37 PM</b> , from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>B. M. Schindler</b>   |  | ADDRESS (Street, city or town, state)<br><b>43 Everett Cumberland Md 8/21/59</b>                             |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. BLANE M. SCHINDLER.</b>  |  | DATE SIGNED  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Aug. 26, 1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>  |  | ADDRESS<br><b>Cumberland, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 27 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Thomas</b>                   |  |

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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1  
Page 4  
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages.  
VS A15 (4)  
15M 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08580

8604

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |                                    |  |  |  |  |  |  |  |  |  |
|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b><br>c. LENGTH OF STAY IN 1b <b>22 DAYS</b><br>d. NAME OF HOSPITAL (If not in hospital, write address) <b>WARMICK &amp; MEMORIAL HOSPITAL AVE.</b>  |  |                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>ALLEGANY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b><br>d. STREET ADDRESS <b>1 125 WEST SECOND STREET</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LLOYD</b> Middle <b>R.</b> Last <b>CORNWELL</b>  |  |                                    |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>14</b> Year <b>1959</b>   |  |  |  |  |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>NOVEMBER 18-1917 41</b>                            |  | 9. AGE (In years last birthday) <b>41</b>                            |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman round house</b>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND (Cumberland)</b> |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 13. FATHER'S NAME <b>HARRY L. CORNWELL</b>   |  |                                    |  | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH MORRIS</b>   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |  |                                    |  | 16. SOCIAL SECURITY NO. <b>214-05-8738</b>   |  | INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b> Address        |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lympho blastoma</b><br>202.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>Jan '56.</b> |  |                                    |  |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |                                    |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                                 |  |  |  |
| 21. I certify that I attended the deceased from <b>January 1956</b> to <b>8-14-59</b> , that I last saw the deceased alive on <b>8-14-59</b> , and that death occurred at <b>12:07 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>MD 8/15/59</b><br>ACTUAL SIGNATURE <b>W. F. Williams</b><br>PHYSICIAN'S NAME (Type) <b>DR. WILLIAM F. WILLIAMS</b> <b>122 S. CENTRE STREET, CUMBERLAND, MD.</b>    |  |                                    |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>8-17-1959</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>   |  |  |  | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b> |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b> ADDRESS  |  |                                    |  |  |  | 24a. REC'D BY REGISTRAR <b>AUG 18 '59</b> DATE                         |  | 24b. REGISTRAR'S SIGNATURE <b>Clifford L. F...</b>                   |  |  |  |

# CERTIFICATE OF DEATH

8000

ALLIANCE

ONE RING

MEMORIAL HOSPITAL

LLOYD

WHITE

HARRY L. CORNWELL

CORNWELL

NOVEMBER 10 1907

ELIZABETH CORNWELL

MEMORIAL HOSPITAL

WILLIAM E. WILLIAMS

100 S. CENTRE STREET, CORNWELL, N.J.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08581

8605

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10 DAYS</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGERY</b> Middle <b>V.</b> Last <b>DAVIS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>30</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>NOV. 20, 1924</b> |
| 9. AGE (In years lost birthday) yrs. <b>34</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>FRANK NIXON</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>8 ALMADA SMELTZER</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>INFORMANT</b>  |  |
| 17. ADDRESS (Street, city or town, state)<br><b>WARWICK &amp; MEMORIAL AVENUE<br/>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>  |                                  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>645.0</b> DUE TO <b>low nephron syndrome (renal shut down)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>after cesarean section and tubal ligation</b> DUE TO <b>7 days</b><br>(c) <b>7 days</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>nephrectomy on left side 12 years ago</b>   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>8-20</b> , 19 <b>59</b> , to <b>8-29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-28</b> , 19 <b>59</b> , and that death occurred at <b>1:35 A.M.</b> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE <b>Lewis Brings</b>  |                                  | ADDRESS (Street, city or town, state) <b>57 Green Rd</b>  |  |
| PHYSICIAN'S NAME (Type) <b>DR. LEWIS BRINGS</b>   |                                  | DATE SIGNED <b>8-31-59</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9-I-59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |                                  | ADDRESS<br><b>Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>SEP 3 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur &amp; Harris</b>  |  |

CERTIFICATE OF DEATH

1-8008

ALLIANCE

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CONCRETE

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TO BE

FOR CITY VIEW TOWNSHIP

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8606

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |   |  |  |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b>                                    |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL-WARWICK &amp; MEMORIAL AVES. 430 N. Mechanic St.,</b>  |                                  |   |  | 1 d. STREET ADDRESS   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CLARENCE</b> Middle Last <b>DE HART</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>3</b> Year <b>1959</b>   |   |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 20, 1904</b> |   | 9. AGE (In years last birthday) yrs.<br><b>55</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist Helper</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. Rwy.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Eckman, W. Va.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>THOMAS RICHARD DE HART</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Annie HOYLE</b>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |  | Address<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Coronary Artery Disease</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> |                                  |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) _____ (County) _____ (State) _____   |  |
| 21. I certify that I attended the deceased from <b>8/1/59</b> , 19, to <b>8/3/59</b> , 19, that I last saw the deceased alive on <b>8/2/59</b> , and that death occurred at <b>5:10 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cumberland</b> DATE SIGNED <b>8/5/59</b><br>ACTUAL SIGNATURE <b>[Signature]</b><br>PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b> <b>122 So. Centre St.,</b>  |                                  |   |  |   |   |  |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8/6/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Odd Fellows Cem.</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Philippi, W. Va.</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>  |                                  |   |  | ADDRESS<br><b>Cumberland, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 '59</b>   |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |   |  |  |

05228

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

38127

ALLGAIN  
CLARENDON  
5 DAYS  
CLARENDON  
CLARENDON

MEMORIAL HOSPITAL - BOSTON & BOSTON AVE., BOSTON, MASS.

CLARENDON  
DEATH - 1901

WHITE  
JUNE 20, 1901

U.S.A.

THOMAS RICHARD DE WINT

MEMORIAL HOSPITAL - CLARENDON, MD.

WILLIAM M. R. J. WILLIAMS

1901

1901



8607

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>47 DAYS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b>                                    |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |                                  |   |  | d. STREET ADDRESS<br><b>1 429 GOETHE STREET</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><b>JOSEPH M. DORSEY</b>  |                                  | First Middle Last   |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>28</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>AUGUST 10, 1901</b>  |  | 9. AGE (In years lost birthday) yrs. <b>58</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Pipefitter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CELANESE, Textile</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA Keyser</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>OWEN DORSEY</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MOLLIE KING</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                  | 16. SOCIAL SECURITY NO. <b>214-07-639</b>   |  | INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE, MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>331X Cerebral Vascular Accident</b><br>IMMEDIATE CAUSE (a) DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>9/11</b> , 19 <b>59</b> , to <b>8/28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/27</b> , 19 <b>59</b> , and that death occurred at <b>12:10 AM</b> , from the causes and on the date stated above.  |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Dr. L. Ley Jr.</b>  |                                  |   |  | ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland, Md.</b>  |  | DATE SIGNED <b>8/28/59</b>  |  |
| PHYSICIAN'S NAME (Type) <b>DR. LEO LEY, JR.</b>   |                                  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>8-31-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Burial Park</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli Cumberland, Md.</b>   |                                  |   |  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 3 '59</b>  |  |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |   |  |

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

10223

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - JAS. MONROE, JR.

CERTIFICATE OF DEATH

8007

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8608

## CERTIFICATE OF DEATH

08584

Reg. Dist. No.

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>  |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL<br/>WARWICK &amp; MEMORIAL AVENUES</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>C.</b> Last <b>FORSTER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>27</b> Year <b>1959</b>   |                                      |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>MARCH 15,</b> |
| 9. AGE (In years last birthday)<br><b>67</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.  |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Acetate Dept.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Celanese Corp.</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>JOHN FORSTER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CATHERINE WIEGAND</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217 10 4032</b>  |                                      |
| 17. ADDRESS<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Hypertension</b> DUE TO<br>(c) <b>Cardiovascular disease</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>6 yrs.</b> |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>8/22</b> , 19 <b>59</b> , to <b>8/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/27</b> , 19 <b>59</b> , and that death occurred at <b>10:40 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Algonquin Hotel 8/29/59</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>George M. Simon</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>George M. Simon</b> |                                  |  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 30, 1959</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>SEP 1 '59</b>  |                                      |
| 24b. REGISTRAR'S SIGNATURE<br><b>C. L. S. Thomas</b>   |                                  |  |                                      |

CERTIFICATE OF DEATH

8608

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ALLIANCE

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## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b><br>c. LENGTH OF STAY IN 1b<br><b>12 DAYS</b><br>d. NAME OF HOSPITAL (If not in hospital, write address of institution)<br><b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>ALLEGANY</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ROUTE # 2 WILLIAMS ROAD, CUMBERLAND, MD.</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>ZELDA</b><br>Middle<br><b>MARGARET</b><br>Last<br><b>GOSS</b>   |                                  | 4. DATE OF DEATH<br>Month<br><b>AUGUST</b><br>Day<br><b>12</b><br>Year<br><b>1959</b>  |                                       |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>X MARCH 23</b> |
| 9. AGE (In years from birthday) yrs.<br><b>48</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months<br><b>10</b><br>Days<br><b>12</b><br>Hours<br><b>15</b><br>Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>WEST VIRGINIA Romney</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S. A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                       |
| 13. FATHER'S NAME<br><b>AMOS, BENNETT</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MAY PYLES</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |                                       |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>  |                                  | Address  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain Metastases</b><br>DUE TO <b>171X</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.<br>(b) <b>Carcinoma Cervix with distant</b><br>DUE TO <b>metastasis</b><br>(c) <b>metastasis</b>              |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b><br><b>10 days</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>Nw</b> , 19 <b>58</b> to <b>Aug 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12 Aug</b> , 19 <b>59</b> , and that death occurred at <b>8:40 P M</b> from the causes and on the date stated above.<br>DATE SIGNED<br><b>Carlton Brinsfield</b><br>M.D. <b>232 Baltimore Ave</b><br>ADDRESS (Street, city or town, state) |                                  |  |                                       |
| ACTUAL SIGNATURE<br><b>Carlton Brinsfield</b>  |                                  | DATE SIGNED<br><b>Aug 12 1959</b>  |                                       |
| PHYSICIAN'S NAME (Type)<br><b>DR. CARLTON BRINSFIELD</b>   |                                  | DATE SIGNED<br><b>Aug 12 1959</b>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 15, 1959</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Bur. Park</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>AUG 17 '59</b>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Kenna</b>  |                                  |  |                                       |

1

Page 4

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director. Pages 3 and 4 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

25.95

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8610

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                    | c. LENGTH OF STAY IN 1b<br><b>18 DAYS</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL-WARWICK &amp; MEMORIAL AVE.</b>   |                                    | d. STREET ADDRESS<br><b>938 Maryland Ave.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELSIE</b> Middle <b>A</b> Last <b>GROVE</b>  |                                    | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>4</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>FEBRUARY 23, 1892</b>   |
| 9. AGE (In years last birthday) yrs. <b>67</b>   |                                    | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ownhome</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA Harpers Ferry -USA</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>ROSSER DAILEY</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>RUTH ANN EARL</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                    | 16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>MEMORIAL HOSPITAL- CUMBERLAND, MD.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Recent Anterior Myocardial Infarction</b> DUE TO<br><b>Anteriodic Heart Disease &amp; old posterior infarction</b> (c) <b>years</b> |                                    |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b><br><b>15 days</b><br><b>years</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonitis, st. middle lobe (cleared prior to death)</b>   |                                    |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                    | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 17, 1959</b> , to <b>August 4, 1959</b> , that I last saw the deceased alive on <b>August 3, 1959</b> , and that death occurred at <b>1:40 A.</b> from the causes and on the date stated above.  |                                    |   |  |
| ACTUAL SIGNATURE <b>Wyand P. Doerner, Jr. M.D.</b>   |                                    | ADDRESS (Street, city or town, state) <b>Algonquin Hotel Cumberland, Md.</b>  |  |
| PHYSICIAN'S NAME (Type) <b>DR. WYAND DOERNER.</b>  |                                    | DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>8-7-59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Marys Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpellito Cumberland, Md.</b>  |                                    | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 '59</b>  |  |
| ADDRESS  |                                    | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. K...</b>  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0538

CERTIFICATE OF DEATH

8610

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MEMORIAL HOSPITAL - MEMPHIS, TENN.

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FEBRUARY 27, 1968

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WEST VIRGINIA

ALTA M. EARL

ROBERT D. EARL

MEMORIAL HOSPITAL - MEMPHIS, TENN.

DR. W. H. DICKER

## Reg. Dist. No.

8611

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VS A1S (4)  
ISM 9/SB

8811-5  
CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

Witness: [illegible]  
Date: [illegible]  
Place: [illegible]

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Page 4  
The law requires that the death certificate be executed within 24 hours of death.  
The attending physician and completely filled in by the funeral director.  
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8612 CERTIFICATE OF DEATH

Reg. Dist. No.

08588

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |                               | c. LENGTH OF STAY IN 1b <b>45 MINUTES</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>  |                               | d. STREET ADDRESS <b>1 126 SPRINGDALE STREET</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>DOLLIE</b> First <b>E.</b> Middle <b>HASENBUHLER</b> Last   |                               | 4. DATE OF DEATH <b>AUGUST</b> Month <b>5</b> Day <b>19</b> Year <b>59</b>   |  |
| 5. SEX <b>FEMALE</b> <b>XXXXXX</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>AUGUST 4, 1880</b> |
| 9. AGE (In years last birthday) <b>79</b>  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>VIRGINIA (VIEWTOWN)</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 13. FATHER'S NAME <b>WILLIAM A. UTZ</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>LUCY M. GRIMSLEY</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>none</b>  |  |
| 17. INFORMANT <b>MEMORIAL HOSPITAL</b>   |                               | Address <b>CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>180X</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Carcinoma of R. Kidney</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 mo</b><br>(c) |                               | INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>July 15, 1959</b> , to <b>Aug 5, 1959</b> , that I last saw the deceased alive on <b>Aug 5, 1959</b> , and that death occurred at <b>1:55 P.M.</b> from the causes and on the date stated above.  |                               |  |  |
| ACTUAL SIGNATURE <b>Clay E. Durrett</b>  |                               | ADDRESS (Street, city or town, state) <b>236 W. 1st Cumberland Md</b> DATE SIGNED <b>8/5/59</b>  |  |
| PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>   |                               |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Aug. 8, 1959</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>  |                               | ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR <b>AUG 10 '59</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |  |

ALLEGANY

WARRAND

WARRAND

WARRAND

WARRAND

WARRAND

WARRAND

150 SPRINGDALE STREET

WARRAND

WARRAND

WARRAND

WARRAND

WARRAND

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WARRAND

WARRAND



8613

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                     | c. LENGTH OF STAY IN lb<br><b>77 DAYS</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ARDEN</b> Middle <b>Wade</b> Last <b>HAYCOCK</b>   |                                     | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>22</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>NOV. 26, 1909</b>                                   |
| 9. AGE (In years last birthday)<br><b>49</b> yrs.  |                                     | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plant laborer</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>QUEEN CITY DAIRY</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>OKONOKO, W.VA.</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>WADE H. HAYCOCK</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>ALICE Gloyd</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No,</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>215-20-5209</b>  |  |
| 17. INFORMANT<br><b>WARWICK &amp; MEMORIAL AVENUE</b>  |                                     | 18. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma lung (left.)</b><br>DUE TO <b>Skeletal metastasis.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.<br>(b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>March 158</b> |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>March 19 58</b> to <b>8-22-59</b> that I last saw the deceased alive on <b>8-21-59</b> , and that death occurred at <b>5:02AM</b> , from the causes and on the date stated above.   |                                     |  |  |
| ACTUAL SIGNATURE <b>M. J. Williams</b> M.D.  |                                     | ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>8-22-59</b>   |  |
| PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>   |                                     | 122 So. Centre St.,  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>8/24/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Ashby Cem.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Fort Ashby, W. Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b>   |                                     | ADDRESS<br><b>Cumberland, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>AUG 25 '59</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hume</b>  |  |

1

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours of death. The law requires that the death certificate be executed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1913

ALLGARY

MARYLAND

ALLGARY

CLIFORD

17 DAYS

CLIFORD HOSPITAL

HAYCOCK

BROWN

25

AUGUST

1913

WHITE

MALE

1810 1800

CLIFORD HOSPITAL

CLIFORD HOSPITAL

MADE H. HAYCOCK

ALICE

WILKINSON HOSPITAL

CLIFORD HOSPITAL - CLIFORD HOSPITAL

*Handwritten signature*

*Handwritten signature*

*Handwritten signature*

DR. W.E. WELLS

DR. W.E. WELLS

CLIFORD HOSPITAL

CLIFORD HOSPITAL

CLIFORD HOSPITAL

## CERTIFICATE OF DEATH

Reg. Dist. No.

8645

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>6 days</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>MINERS HOSPITAL</b>  |                                  | e. STREET ADDRESS<br><b>1 10 ORMOND ST.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MARGARET HIGGINS</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>AUGUST 23, 19 59</b>   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUG. 15, 1882</b> |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWORK</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>GEORGE TIPPEN</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET MORGAN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |
| INFORMANT<br><b>LA VERNE HIGGINS, FROSTBURG, MD.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intestinal obstruction due to anular carcinoma (with gangrenous perforation of the sigmoid)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>10 days</b><br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug. 21, 1959</b> , to <b>Aug. 23, 1959</b> that I last saw the deceased alive on <b>Aug. 23, 1959</b> , and that death occurred at <b>5:35 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b> DATE SIGNED <b>8/25/59</b>   |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Hilda Jane Walters</b> M.D.   |                                  | DATE SIGNED<br><b>8/25/59</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Hilda Jane Walters, M.D.</b>   |                                  | Frostburg, Md.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>AUG. 26 '59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MICHAEL'S CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>FROSTBURG, MD.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. DURST, FROSTBURG, MD.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 27 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>  |                                  |   |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05530

CERTIFICATE OF DEATH

2045

ALLIANCE

WESTWARD

0000

WESTERN HOSPITAL

AUGUST

HIGHWAY

WARRANT

77

AND. II. 1952

WHITE

THOMAS

U.S.A.

WESTWARD

ONE HOUR

FOURTH

MARGARET MORAN

EDWARD STEPHEN

WESTWARD, IN

HOME

Investigation of the cause of death and the manner of death is complete and the cause of death is ascertained.

519123

WESTWARD, MO.

WESTWARD, MO.

AUG. 24, 1952

WESTWARD, MO.

8645

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Allegany</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>  |  | c. LENGTH OF STAY IN 1b   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Allegany</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Gilmore, R.F.D. #1. Frostburg, MD.</b> |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miners Hospital</b>   |  |   |  |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>WILLIAM S. JOHNSON</b>   |  | First Middle Last   |  | 4. DATE OF DEATH<br><b>8/28/1959</b>  |  | Month Day Year   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>8/17/1892</b>                                 |  | 9. AGE (In years last birthday)<br><b>69</b> yrs.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self employed Merchant</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Borden Shaft, MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                        |  |   |  |
| 13. FATHER'S NAME<br><b>John G. Johnson</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Jane Ann Ternent</b>   |  |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-32-2881</b>   |  | 17. INFORMANT<br><b>Mrs. Hannah Grindle, Gilmore, MD.</b>   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>526x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Failure of respiratory center</b><br>(c) <b>Pulmonary Emphysema + Fibrosis</b><br><b>Chronic Bronchitis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs.</b><br><b>20 yrs.</b><br><b>5 yrs.</b><br><b>25 yrs.</b>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Thrombosis of femoral artery &amp; vein - amputation</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Frostburg</b>                              |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>April 28, 1957</b> , to <b>August 28, 1959</b> , that I last saw the deceased alive on <b>Aug. 28, 1959</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above.   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Frank T. Harrat</b>   |  | ADDRESS (Street, city or town, state)<br><b>26 West Mechanic St.</b>                                      |  | DATE SIGNED   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>FRANK T. HARRAT MD</b>   |  |   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8/31/1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |  | 22d. LOCATION (City, town, or county)<br><b>Frostburg, Maryland.</b> |  | (State)   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>GEORGE EICHORN</b>  |  | ADDRESS<br><b>LONACONING, MD.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>SEP 1 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Harrat</b>                |  |   |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)  
15M 10/57

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8614

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |  |  |   |
|---|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |                                  |   |  | c. LENGTH OF STAY IN 1b <b>26 DAYS</b>  |  |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>   |                                  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last <b>CHARLES Francis KAISER Sr.</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month Day Year <b>AUGUST 29 19 59</b>   |  |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 18, 1891</b>                        | 9. AGE (In years last birthday)<br><b>68</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours                         | IF UNDER 24 HRS.<br>Min.                             |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cumb steel company</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |
| 13. FATHER'S NAME<br><b>HENRY KAISER (DECEASED)</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH NICHOL (DECEASED)</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-05-7771</b>   |  | INFORMANT Address<br><b>PATIENTS CHART</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>190.9</b> <b>cochexia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>malignant melanoma</b><br>DUE TO<br>(c) <b>6 months</b>  |                                  |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                 |   |
| 21. I certify that I attended the deceased from <b>August 29, 19 59</b> to <b>August 29, 19 59</b> , that I last saw the deceased alive on <b>August 29, 19 59</b> , and that death occurred at <b>6:00 AM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>55 GREENE ST., CUMBERLAND, MARYLAND.</b><br>DATE SIGNED <b>8-30-59</b><br>ACTUAL SIGNATURE <b>Lewis Brings</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b> |                                  |   |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>8/31/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>S.S. Peter &amp; Paul Cemetery Cumberland Maryland</b>   |  | 22d. LOCATION (City, town, or county) (State)        |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b>   |                                  |   |  | ADDRESS<br><b>Cumberland Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 1 '59</b>     |   |
|   |                                  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b> |   |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                                  |  |                                 |  |                                       |  |
|----------------------------------|--|---------------------------------|--|---------------------------------------|--|
| 1. Name of Deceased              |  | 2. Sex                          |  | 3. Age                                |  |
| 4. Date of Death                 |  | 5. Time of Death                |  | 6. Place of Death                     |  |
| 7. Cause of Death                |  | 8. Manner of Death              |  | 9. Signature of Registrar             |  |
| 10. Signature of Medical Officer |  | 11. Signature of Coroner        |  | 12. Signature of Police Officer       |  |
| 13. Signature of Burial Officer  |  | 14. Signature of Undertaker     |  | 15. Signature of Witness              |  |
| 16. Signature of Family Member   |  | 17. Signature of Friend         |  | 18. Signature of Neighbor             |  |
| 19. Signature of Clergyman       |  | 20. Signature of Minister       |  | 21. Signature of Priest               |  |
| 22. Signature of Bishop          |  | 23. Signature of Cardinal       |  | 24. Signature of Pope                 |  |
| 25. Signature of Emperor         |  | 26. Signature of King           |  | 27. Signature of Queen                |  |
| 28. Signature of President       |  | 29. Signature of Prime Minister |  | 30. Signature of Governor             |  |
| 31. Signature of Mayor           |  | 32. Signature of Town Clerk     |  | 33. Signature of Justice of the Peace |  |
| 34. Signature of Magistrate      |  | 35. Signature of Sheriff        |  | 36. Signature of Bailiff              |  |
| 37. Signature of Constable       |  | 38. Signature of Watchman       |  | 39. Signature of Night Watchman       |  |
| 40. Signature of Watchdog        |  | 41. Signature of Cat            |  | 42. Signature of Dog                  |  |
| 43. Signature of Bird            |  | 44. Signature of Fish           |  | 45. Signature of Insect               |  |
| 46. Signature of Plant           |  | 47. Signature of Tree           |  | 48. Signature of Flower               |  |
| 49. Signature of Fruit           |  | 50. Signature of Vegetable      |  | 51. Signature of Grain                |  |
| 52. Signature of Seed            |  | 53. Signature of Root           |  | 54. Signature of Stem                 |  |
| 55. Signature of Leaf            |  | 56. Signature of Branch         |  | 57. Signature of Twig                 |  |
| 58. Signature of Bark            |  | 59. Signature of Sap            |  | 60. Signature of Resin                |  |
| 61. Signature of Gum             |  | 62. Signature of Oil            |  | 63. Signature of Juice                |  |
| 64. Signature of Milk            |  | 65. Signature of Honey          |  | 66. Signature of Butter               |  |
| 67. Signature of Cheese          |  | 68. Signature of Meat           |  | 69. Signature of Fish                 |  |
| 70. Signature of Poultry         |  | 71. Signature of Game           |  | 72. Signature of Beast                |  |
| 73. Signature of Bird            |  | 74. Signature of Insect         |  | 75. Signature of Reptile              |  |
| 76. Signature of Amphibian       |  | 77. Signature of Mammal         |  | 78. Signature of Fish                 |  |
| 79. Signature of Shellfish       |  | 80. Signature of Mollusk        |  | 81. Signature of Crustacean           |  |
| 82. Signature of Arachnid        |  | 83. Signature of Insect         |  | 84. Signature of Plant                |  |
| 85. Signature of Tree            |  | 86. Signature of Flower         |  | 87. Signature of Fruit                |  |
| 88. Signature of Seed            |  | 89. Signature of Root           |  | 90. Signature of Stem                 |  |
| 91. Signature of Leaf            |  | 92. Signature of Branch         |  | 93. Signature of Twig                 |  |
| 94. Signature of Bark            |  | 95. Signature of Sap            |  | 96. Signature of Resin                |  |
| 97. Signature of Gum             |  | 98. Signature of Oil            |  | 99. Signature of Juice                |  |
| 100. Signature of Milk           |  | 101. Signature of Honey         |  | 102. Signature of Butter              |  |
| 103. Signature of Cheese         |  | 104. Signature of Meat          |  | 105. Signature of Fish                |  |
| 106. Signature of Poultry        |  | 107. Signature of Game          |  | 108. Signature of Beast               |  |
| 109. Signature of Bird           |  | 110. Signature of Insect        |  | 111. Signature of Reptile             |  |
| 112. Signature of Amphibian      |  | 113. Signature of Mammal        |  | 114. Signature of Fish                |  |
| 115. Signature of Shellfish      |  | 116. Signature of Mollusk       |  | 117. Signature of Crustacean          |  |
| 118. Signature of Arachnid       |  | 119. Signature of Insect        |  | 120. Signature of Plant               |  |

8654

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                     |  |  |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>15yrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>R.D. #1, Box 71 (Shaft)</b>  |                                     | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>KAMAUF</b>   |                                     | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>26</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-10-17</b>                   |
| 9. AGE (In years last birthday)<br><b>42</b> yrs.   |                                     | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Henry A. Klosterman</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Rose Mae Yeider</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>218-10-1347</b>  |  |
| 17. INFORMANT<br><b>Raymond P. Kamauf, R.D. #1, Box 71, (Shaft)</b>   |                                     | Address <b>Frostburg, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CHRONIC CARDIO-VASCULAR DISEASE</b> DUE TO<br>(c) <b>4 YRS.</b>    |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                                     | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>July 1958</b> to <b>August 26, 1959</b> , that I last saw the deceased alive on <b>August 26, 1959</b> , and that death occurred at <b>8:30 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>2 BROADWAY, Frostburg, Md.</b> DATE SIGNED <b>8/27/59</b> |                                     |  |  |
| ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>   |                                     | PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D. Frostburg, Md.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8-29-59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Park Frostburg, Md.</b>  | 22d. LOCATION (City, town, or county) (State)        |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>SEP 1 '59</b>  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b> |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

|   |  |   |  |
|---|--|---|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p>    |  | <p>2. Sex: <u>Male</u></p>                            |  |
| <p>3. Age: <u>45</u></p>                            |  | <p>4. Date of death: <u>Jan 15 1911</u></p>           |  |
| <p>5. Place of death: <u>Home</u></p>               |  | <p>6. Cause of death: <u>Heart Disease</u></p>        |  |
| <p>7. Occupation: <u>Engineer</u></p>               |  | <p>8. Usual residence: <u>123 Main St, Boston</u></p> |  |
| <p>9. Name of physician: <u>Dr. J. A. Smith</u></p> |  | <p>10. Name of undertaker: <u>John Doe</u></p>        |  |
| <p>11. Name of informant: <u>John Doe</u></p>       |  | <p>12. Signature of informant: <u>[Signature]</u></p> |  |
| <p>13. Name of registrar: <u>John Doe</u></p>       |  | <p>14. Signature of registrar: <u>[Signature]</u></p> |  |

## 8615 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b><br>MARYLAND  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                       | c. LENGTH OF STAY IN 1b<br><b>6/2/56</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>D.</b> Last <b>Kroll</b>   |                                       | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>16</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/5/1875</b>   |
| 9. AGE (In years last birthday)<br><b>84</b> yrs.   |                                       | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                       | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pekin, Maryland</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Daniel Lewis</b>  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Annie Carthew</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                       | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |   |
| 17. INFORMANT<br><b>P.O.Box 599</b>   |                                       | Address <b>Cumberland, Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b><br>DUE TO <b>Chronic Myocardial Degeneration</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b><br>DUE TO (c) <b>Chronic Osteo-arthritis</b> |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Osteo-arthritis</b>   |                                       |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>6/2/56</b> , 19____, to <b>8/16/59</b> , 19____, that I last saw the deceased alive on <b>8/15/59</b> , 19____, and that death occurred at <b>4:15 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>8/17/59</b>   |                                       |  |   |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |                                       | DATE SIGNED <b>8/17/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>  |                                       | <b>Cumberland, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8/18/1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Lonaconing, Maryland.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>GEORGE EICHHORN</b>  |                                       | ADDRESS<br><b>LONACONING, MD.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>DATE AUG 20 '59</b>   |                                       | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Head</b>  |   |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE 02/15/00

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08595

Reg. Dist. No.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  | c. LENGTH OF STAY IN 1b<br><b>50 yrs.</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>100 Arch St.</b>  |   | d. STREET ADDRESS<br><b>1 100 Arch St.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Charley N. Mansberry</b>   |   | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>18</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 26, 1882</b> |
| 9. AGE (in years last birthday)<br><b>77</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Yd. Foreman Railroad</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Garrett, Penna.</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Jacob Mansberry</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth May</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b>705-10-8556</b>   |   |
| 17. INFORMANT<br><b>Mrs. Chaley Mansberry, Cumberland, Md.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>Sudden</b> |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |   |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 22b. DATE THEREOF<br><b>8-21-1959</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Herman Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 21 '59</b>   |   |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |   |



8647

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>131 Philos Ave.</b>  |                                     | e. STREET ADDRESS<br><b>131 Philos Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maggie</b> Middle <b>G.</b> Last <b>Martin</b>  |                                     | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>23</b> Year <b>1959</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 22, 1871</b>                                |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.   |                                     | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Book-keeper</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Marble Works</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Joseph Martin</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Kathryn Johnson</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |                                     | 16. SOCIAL SECURITY NO.<br><b>232-26-3310H</b>   |   |
| 17. INFORMANT<br><b>Miss Eleanor Cogan, Westernport, Md.</b>  |                                     | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastatic Cancer</b><br>DUE TO<br>(c) <b>Cancer of Breast.</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>6 months</b><br><b>30 years</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Coronary Arteriosclerosis</b>   |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>October 1958</b> , to <b>Aug 23, 1959</b> , that I last saw the deceased alive on <b>Aug 23, 1959</b> , and that death occurred at <b>10:35 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED                            |                                     |  |   |
| ACTUAL SIGNATURE<br><b>William W. Lesh</b> M.D.   |                                     | DATE SIGNED<br><b>Aug 26 '59</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Wm. W. Lesh</b>   |                                     | Main St. Westernport, Md.  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8/26/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport, Md</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Mullock Jr.</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>Aug 26 '59</b>   |   |
| ADDRESS<br><b>Piedmont, W. Va.</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |   |



8648

Items 8.9 Film G246 8-24-59 et

## CERTIFICATE OF DEATH

08597

Reg. Dist. No.

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>6 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>R.F.D. Westernport</b>                               |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kooken Nursing Home</b>   |                                  |   |   | d. STREET ADDRESS<br><b>1</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Samuel</b> Middle <b>Martin</b> Last <b>Martin</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Aug</b> Day <b>16</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 22, 1877</b> | 9. AGE (In years last birthday)<br><b>81</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>16</b> Hours <b>12</b> Min. <b>59</b> | IF UNDER 24 HRS.<br>Months <b>8</b> Days <b>16</b> Hours <b>12</b> Min. <b>59</b>                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Coal Miner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Mines</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>HENRY MARTIN</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>not known</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |   | INFORMANT Address<br><b>Leslie Martin-Detroit, Mich</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>446X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Chronic Nephritis</b><br>(c) <b>Arterio-sclerosis</b><br><b>UREMIA</b>  |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 Days</b><br><b>5 Years</b><br><b>5 Years</b>             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>JAN 10, 1958</b> , to <b>AUG 16, 1959</b> , that I last saw the deceased alive on <b>AUG. 16, 1959</b> , and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Paul R. Wilson</b> M.D. <b>1145 RICHMOND, Piedmont, W. Va.</b> <b>8-17-59</b> |                                  |   |   |   |  |   |  |
| ACTUAL SIGNATURE   |                                  | PHYSICIAN'S NAME (Type)<br><b>Paul R. Wilson, M.D.</b>  |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8/8/59</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow Maryland</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. J. Brou</b>  |                                  |   |   | ADDRESS<br><b>Westernport, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 21 1959</b>  |  |
|  |                                  |   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |  |   |  |

Page 4 of 4  
 The law requires that the death certificate be executed on 24 hours after death.  
 The attending physician and completely filled in by the funeral director, with page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

DATE OF DEATH

TIME OF DEATH

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CAUSE OF BIRTH





8817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| NAME OF DECEASED<br>JAMES H. HARRIS     |  | AGE<br>45                  |  | SEX<br>Male                                  |  | RACE<br>White                            |  |
| DATE OF DEATH<br>April 1, 1917          |  | PLACE OF DEATH<br>Home     |  | CITY<br>Baltimore                            |  | COUNTY<br>Baltimore                      |  |
| CAUSE OF DEATH<br>Myocardial Infarction |  | MANNER OF DEATH<br>Natural |  | DISEASE OR INJURY<br>Coronary Artery Disease |  | LOCALITY OF BIRTH<br>Maryland            |  |
| EDUCATION<br>High School                |  | OCCUPATION<br>Clerk        |  | MARITAL STATUS<br>Married                    |  | RELIGION<br>Roman Catholic               |  |
| PREVIOUS ILLNESS<br>None                |  | TREATMENT<br>None          |  | HISTORY OF ALCOHOLIC DRINKING<br>Occasional  |  | HISTORY OF TOBACCO SMOKING<br>Occasional |  |
| FAMILY HISTORY<br>None                  |  | SOCIAL HISTORY<br>None     |  | HISTORY OF MENTAL ILLNESS<br>None            |  | HISTORY OF PHYSICAL ILLNESS<br>None      |  |
| SIGNATURE OF EXAMINER<br>J. H. Harris   |  | DATE<br>April 1, 1917      |  | PLACE<br>Baltimore                           |  | COUNTY<br>Baltimore                      |  |

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8618 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08599

Reg. Dist. No.

|   |                               |  |   |  |  |
|---|-------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |                               | c. LENGTH OF STAY IN 1b <b>At once</b>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B &amp; O Railroad Station</b>  |                               |  | d. STREET ADDRESS <b>210 Union Street</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <b>Robert Franklin Mills</b>  |                               |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>25</b> Year <b>1959</b>  |  |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>June 28, 1906</b>   |  | 9. AGE (In years last birthday) <b>53</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B &amp; O Bolt &amp; Forge</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>  |   | 11. BIRTHPLACE (State or foreign country) <b>Oakland, Maryland</b>                         |  |
| 13. FATHER'S NAME <b>Samuel Mills</b>   |                               |  | 14. MOTHER'S MAIDEN NAME <b>May Pifer</b>   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>705-07-9642</b>   |   | 17. INFORMANT <b>Robert Mills</b> <b>210 Union Street Cumberland, Maryland</b>             |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Transection of entire body</b><br><b>802x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Run over by Railroad train</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) |                               |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>Sudden</b>                             |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Run over by B &amp; O Passenger train</b>                |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year <b>8:55 a.m. Aug. 26 1959</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>R.R. Station</b> |  |
|   |                               |  |   | 20f. (City or town) <b>Cumberland, Alleg. Md.</b> (County) (State)                         |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>                         |                               |  |   |  |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED  |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>   |                               | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>Aug. 28, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>                            |  |
|   |                               |  |   | 22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b> (State)                  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>   |                               |  | 24a. REC'D BY REGISTRAR <b>AUG 31 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krum</b>   |

NEWYLAND STATE DEPARTMENT OF HEALTH - BATHING  
8612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                  |  |                       |  |                          |  |               |  |                    |  |                 |  |                       |  |                      |  |                        |  |                    |  |                      |  |                   |  |
|------------------|--|-----------------------|--|--------------------------|--|---------------|--|--------------------|--|-----------------|--|-----------------------|--|----------------------|--|------------------------|--|--------------------|--|----------------------|--|-------------------|--|
| Name of Deceased |  | Age                   |  | Sex                      |  | Race          |  | Color              |  | Religion        |  | Marital Status        |  | Occupation           |  | Residence              |  | Date of Death      |  | Time of Death        |  | Place of Death    |  |
| Robert           |  | Male                  |  | White                    |  | Caucasian     |  | Caucasian          |  | Catholic        |  | Single                |  | Farmer               |  | Rural                  |  | 1900               |  | 10:00 AM             |  | Farm              |  |
| Cause of Death   |  | Immediate Cause       |  | Intermediate Cause       |  | Remote Cause  |  | Contributing Cause |  | Manner of Death |  | Signature of Examiner |  | Signature of Coroner |  | Signature of Physician |  | Signature of Juror |  | Signature of Witness |  | Signature of Jury |  |
| Heart failure    |  | Myocardial infarction |  | Coronary atherosclerosis |  | Hypertension  |  | Cholesterol        |  | Natural         |  | [Signature]           |  | [Signature]          |  | [Signature]            |  | [Signature]        |  | [Signature]          |  | [Signature]       |  |
| Time of Death    |  | Place of Death        |  | Date of Death            |  | Time of Death |  | Place of Death     |  | Date of Death   |  | Time of Death         |  | Place of Death       |  | Date of Death          |  | Time of Death      |  | Place of Death       |  | Date of Death     |  |
| 10:00 AM         |  | Farm                  |  | 1900                     |  | 10:00 AM      |  | Farm               |  | 1900            |  | 10:00 AM              |  | Farm                 |  | 1900                   |  | 10:00 AM           |  | Farm                 |  | 1900              |  |

8619

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |  |  |   | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.</b>   |  |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>H. MULLANEY</b> Middle <b>LAST</b>   |  |  |   | 4. DATE OF DEATH <b>AUG.</b> Month <b>26</b> Day <b>19</b> Year <b>59</b>  |  |  |  |
| 5. SEX <b>MALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>NOV. 7, 1905</b>                                 |  |
| 9. AGE (In years last birthday) <b>53</b> yrs.  |  | IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. |   | IF UNDER 24 HRS. Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>  |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>WINDSOR HOTEL CO.</b>   |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <b>MT. SAVAGE, MD.</b>  |  |  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |  |  |
| 13. FATHER'S NAME <b>HENRY MULLANEY</b>   |  |  |   | 14. MOTHER'S MAIDEN NAME <b>LORETTA MALLOY</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  |  |   | 16. SOCIAL SECURITY NO. <b>XXXXXXXXXX 214-05-8016</b>  |  |  |  |
| 17. INFORMANT <b>MRS. THOMAS MULLANEY -CUMBERLAND, MD.</b>  |  |  |   | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>430.1</b> DUE TO <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Very short time</b> |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |
| 20f. (City or town) (County) (State)  |  |  |   |  |  |  |  |
| 21. I certify that I attended the deceased from <b>11. 7. 1956</b> to <b>8. 26. 1959</b> that I last saw the deceased alive on <b>8. 26. 1959</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.  |  |  |   |  |  |  |  |
| ACTUAL SIGNATURE <b>W. F. Williams</b> M.D. <b>Cumberland, Md 8-24-59</b>   |  |  |   | ADDRESS (Street, city or town, state) <b>CUMBERLAND, MD.</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>   |  |  |   |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 22b. DATE THEREOF <b>8-29-59</b>                                     |   | 22c. NAME OF CEMETERY OR CREMATORY <b>SS. PETER &amp; PAUL CEM.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc. Cumberland, Md</b>  |  |  |   | 24a. REC'D BY REGISTRAR <b>SEP 1 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>                    |  |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08601

Items 4, 20c Film G248 9-17-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   | c. LENGTH OF STAY IN Yr<br><b>40yrs</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland 02</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>  |  | d. STREET ADDRESS<br><b>1004 Oldtown Road</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>William P Mulvey</b>  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>16</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 14, 1898</b>  |
| 9. AGE (In years last birthday)<br><b>61</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>16</b> Days <b>14</b> Hours <b>15</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Carman</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad, B&amp;O</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Fairmont, W. Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Michael Mulvey</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Little</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, give war or dates of service)<br><b>War I Yes</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705-12-4219</b>   |   |
| 17. INFORMANT<br><b>Miss Marietta Mulvey</b>  |  | Address<br><b>1004 Oldtown R D</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b><br><b>900.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Skull Fracture</b><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>18 Hrs.</b><br><b>18 Hrs.</b> |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell down steps at home</b>                              |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>1:00 p.m. Aug. 14, 1959</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   | 20f. (City or town) (County) (State)<br><b>Cumberland, Alleg. Md.</b>                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarello</b> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarello, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED <b>August 15, 1959</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8-17-59</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DATE AUG 18 '59</b>   |   |
| ADDRESS<br><b>Cumberland, Md.</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |   |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
8850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| NAME OF DECEASED<br>JAMES H. GOSWELL   |  | AGE<br>65  |  | SEX<br>M   |  | RACE<br>W  |  |
| DATE OF DEATH<br>JAN 15 1950   |  | PLACE OF DEATH<br>HOME   |  | CITY<br>BALTIMORE  |  | COUNTY<br>BALTIMORE  |  |
| OCCUPATION<br>RETIRED  |  | EDUCATION<br>HIGH SCHOOL   |  | MARRIAGE<br>M  |  | RELIGION<br>METHODIST  |  |
| CAUSE OF DEATH<br>CORONARY THROMBOSIS  |  | MANNER OF DEATH<br>NATURAL   |  | IMMEDIATE CAUSE<br>HEART ATTACK  |  | UNDERLYING CAUSE<br>CORONARY THROMBOSIS  |  |
| SIGNS AND SYMPTOMS<br>PAIN IN CHEST, SHORTNESS OF BREATH, SWEATING   |  | PRE-MORAL HISTORY<br>HYPERTENSION, SMOKE 20 CIGARETTES PER DAY   |  | HISTORY OF DISEASE<br>CORONARY DISEASE, 10 YEARS   |  | HISTORY OF TREATMENT<br>DIGITALIS, NITROGLYCERINE  |  |
| PHYSICIAN'S SIGNATURE<br>J. H. GOSWELL   |  | PHYSICIAN'S NAME<br>J. H. GOSWELL  |  | PHYSICIAN'S ADDRESS<br>1234 E. BALTIMORE AVE.  |  | PHYSICIAN'S PHONE<br>1234  |  |
| DEATH CERTIFICATE<br>I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased. |  | DEATH CERTIFICATE<br>I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased. |  | DEATH CERTIFICATE<br>I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased. |  | DEATH CERTIFICATE<br>I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased. |  |

8621

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>13 DAYS</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL<br/>MEMORIAL &amp; WARWICK AVES.</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>MC INTYRE</b> Last <b>MURPHY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>17</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>APRIL 13, 1884</b>      |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Miner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Mine</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>WILLIAM MURPHY</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL,</b>  |                                  | Address<br><b>CUMBERLAND, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma esophagus</b><br>150x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized metastasis</b><br>DUE TO<br>(c) <b>generalized metastasis</b>   |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>8/14</b> , 19 <b>57</b> , to <b>8/17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/17</b> , 19 <b>57</b> , and that death occurred at <b>3:00 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Algonquin Hotel 8/19/57</b><br>DATE SIGNED<br>ACTUAL SIGNATURE <b>George M. Brown</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>DR. W.A. VAN ORMER</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>8/20/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Lonaconing, Md</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Eichhorn</b>  |                                  | ADDRESS<br><b>Lonaconing, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 24 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Harris</b>   |  |

STATE OF NEW YORK

1921

WILLIAM HENRY

WILLIAM HENRY

13 DAYS

WILLIAM HENRY

MEMORIAL HOSPITAL  
100 WEST 117TH STREET

100 WEST 117TH STREET

JOHN

JOHN

JOHN

WHITE

WHITE

WILLIAM HENRY

WILLIAM HENRY

WILLIAM HENRY

WILLIAM HENRY

WILLIAM HENRY

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

DR. W. J. VAN DER

DR. W. J. VAN DER

DR. W. J. VAN DER

DR. W. J. VAN DER

DR. W. J. VAN DER

DR. W. J. VAN DER

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8649

## CERTIFICATE OF DEATH

08603

Reg. Dist. No.

|   |                               |   |                                       |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>   |                               | c. LENGTH OF STAY IN TB <b>24 years</b>   |                                       |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>  |                               | d. STREET ADDRESS <b>109 McCulloh Street</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 McCulloh Street</b>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Russell J. Nine</b>  |                               | 4. DATE OF DEATH <b>August 7, 1959</b>  |                                       |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>June 17, 1906</b> |
| 9. AGE (In years last birthday) <b>53</b> yrs.  |                               | IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Silk Mill Worker</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Silk Mill</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Elkins, West Virginia</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                       |
| 13. FATHER'S NAME <b>Charles Nine</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Agnes Brown</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>   |                               | 16. SOCIAL SECURITY NO. <b>217-10-7548</b>  |                                       |
| 17. INFORMANT <b>Mrs. Russell Nine, 109 McCulloh Street, Frostburg, Md.</b>   |                               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b><br><b>442X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 mo</b><br>DUE TO (c) |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>June 26, 1959</b> , to <b>Aug 7, 1959</b> , that I last saw the deceased alive on <b>June 26, 1959</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Frostburg Aug 9 1959</b><br>DATE SIGNED <b>md</b> |                               |   |                                       |
| ACTUAL SIGNATURE <b>W O Mc Lane</b> M.D.  |                               | PHYSICIAN'S NAME (Type) <b>W O Mc Lane MD</b>   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>August 9, '59</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Harer</b> Home Address <b>Frostburg, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>   |                                       |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>   |                               |   |                                       |





TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8622

## CERTIFICATE OF DEATH

Reg. Dist. No.

08604

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>   |                               | c. LENGTH OF STAY IN 1b <b>46 days</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>P</b> Last <b>Ogle</b>   |                               | 4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 59</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>Color</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Feb. 3, 1891</b>   |
| 9. AGE (In years last birthday) <b>68</b> yrs.   |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  | 11. BIRTHPLACE (State or foreign country) <b>W Va. Pattersons Creek U.S.A.</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                               | 13. FATHER'S NAME <b>Kx James Ogle Tire Co.</b>  |  |
| 14. MOTHER'S MAIDEN NAME <b>Nancy ?</b>  |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW 1</b>   |  |
| 16. SOCIAL SECURITY NO. <b>217-10-6449</b>   |                               | INFORMANT <b>Pt's chart</b> Address  |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>uremia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis</b> DUE TO (c) <b>2 months</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>years</b> |                               | 18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 50</b> to <b>8/20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 20</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>43 Greene Street Cumberland Md</b> DATE SIGNED <b>8/22/59</b>                 |                               |  |  |
| ACTUAL SIGNATURE <b>B. M. Schuller</b> M.D. <b>43</b>  |                               | PHYSICIAN'S NAME (Type) <b>Dr. S. G. Weisman</b> <b>43</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Aug. 22, 1959</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Bur. Park</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>  |                               | 24a. REC'D BY REGISTRAR <b>AUG 26 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>  |                               |  |  |

10000

THE HOUSE OF DEATH

8888



John J. Baker, Comptroller, England

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08605

Reg. Dist. No.

|  |                                  |   |   |  |   |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2 Miltenberger Street</b>   |                                  |   | d. STREET ADDRESS<br><b>2 Miltenberger St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>C.</b> Last <b>O'Hara</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>14</b> Year <b>1959</b>  |  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 2, 1905</b>   |  | 9. AGE (In years last birthday)<br><b>54</b> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist Helper</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Md.</b>                                      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |   | 13. FATHER'S NAME<br><b>Dennis O'Hara</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary V. Kelly</b>   |                                  |   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>yes War II</b>              |  |   |
| 16. SOCIAL SECURITY NO.<br><b>705-05-5256</b>  |                                  |   | 17. INFORMANT<br><b>Mrs. Ralph O'Hara, Cumberland, Md.</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b><br>(a), stating the underlying cause last. DUE TO (c) _____  |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br>-----  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |   |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a. m.</b> <b>19</b><br>p. m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |   |
| 20f. (City or town)  |                                  | (County)  |   | (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |  |   |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED  |   |
| EXAMINER'S NAME (Type)<br><b>Benedict Skitarelic, M.D.</b>   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | <b>Aug. 15, 1959</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 18, 1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>  |   |
| 22d. LOCATION (City, town, or county)<br><b>Cumberland, Md.</b>  |                                  | (State)   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>   |                                  |   | 24a. REC'D BY REGISTRAR<br><b>DATE AUG 18 '59</b>   |  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8655 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

08606

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>La Vale</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>13 Richard Way, Coverwood</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Betty</b> Middle <b>Louise</b> Last <b>Payne</b>   |                                  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>9</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>May 2, 1917</b>   |
| 9. AGE (In years last birthday)<br><b>42</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>  | IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pittsburgh, Pennsylvania</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>William L. Deakins</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Gunter</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>168-09-5541</b>  |  |
| 17. INFORMANT<br><b>Roy W. Payne</b>   |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br><b>170X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA OF BREAST</b><br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6.8 MOS</b><br><b>4 YEARS</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Aug 8, 1959</b> , to <b>Aug 8, 1959</b> , that I last saw the deceased alive on <b>Aug 8, 1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>441 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>8-10-59</b> |                                  |  |  |
| ACTUAL SIGNATURE <b>William P. James</b> M.D.  |                                  | PHYSICIAN'S NAME (Type) <b>William P. James M.D.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 13, 1959</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Jefferson Mem. Park</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Pittsburgh, Pennsylvania</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Aug 14 59</b><br>DATE  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneiss</b>  |                                  |  |  |

8655

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

Page One

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| <p>1. Name of Deceased<br/>John J. Miller</p> |  | <p>2. Sex<br/>Male</p>                            |  | <p>3. Date of Birth<br/>1901</p>           |  | <p>4. Date of Death<br/>1955</p>             |  |
| <p>5. Place of Birth<br/>Maryland</p>         |  | <p>6. Usual Residence<br/>Baltimore, Maryland</p> |  | <p>7. Cause of Death<br/>Heart Disease</p> |  | <p>8. Manner of Death<br/>Natural</p>        |  |
| <p>9. Occupation<br/>None</p>                 |  | <p>10. Education<br/>None</p>                     |  | <p>11. Marital Status<br/>Married</p>      |  | <p>12. Name of Spouse<br/>None</p>           |  |
| <p>13. Name of Physician<br/>None</p>         |  | <p>14. Name of Hospital<br/>None</p>              |  | <p>15. Name of Funeral Home<br/>None</p>   |  | <p>16. Name of Undertaker<br/>None</p>       |  |
| <p>17. Name of Coroner<br/>None</p>           |  | <p>18. Name of Medical Examiner<br/>None</p>      |  | <p>19. Name of Pathologist<br/>None</p>    |  | <p>20. Name of Anatomist<br/>None</p>        |  |
| <p>21. Name of Registrar<br/>None</p>         |  | <p>22. Name of Clerk<br/>None</p>                 |  | <p>23. Name of Stenographer<br/>None</p>   |  | <p>24. Name of Typewriter<br/>None</p>       |  |
| <p>25. Name of Secretary<br/>None</p>         |  | <p>26. Name of Messenger<br/>None</p>             |  | <p>27. Name of Janitor<br/>None</p>        |  | <p>28. Name of Cook<br/>None</p>             |  |
| <p>29. Name of Nurse<br/>None</p>             |  | <p>30. Name of Doctor<br/>None</p>                |  | <p>31. Name of Surgeon<br/>None</p>        |  | <p>32. Name of Dentist<br/>None</p>          |  |
| <p>33. Name of Pharmacist<br/>None</p>        |  | <p>34. Name of Optician<br/>None</p>              |  | <p>35. Name of Electrician<br/>None</p>    |  | <p>36. Name of Plumber<br/>None</p>          |  |
| <p>37. Name of Carpenter<br/>None</p>         |  | <p>38. Name of Painter<br/>None</p>               |  | <p>39. Name of Bricklayer<br/>None</p>     |  | <p>40. Name of Stonemason<br/>None</p>       |  |
| <p>41. Name of Blacksmith<br/>None</p>        |  | <p>42. Name of Jeweler<br/>None</p>               |  | <p>43. Name of Watchmaker<br/>None</p>     |  | <p>44. Name of Tailor<br/>None</p>           |  |
| <p>45. Name of Hatter<br/>None</p>            |  | <p>46. Name of Shoemaker<br/>None</p>             |  | <p>47. Name of Saddler<br/>None</p>        |  | <p>48. Name of Upholsterer<br/>None</p>      |  |
| <p>49. Name of Cabinetmaker<br/>None</p>      |  | <p>50. Name of Joiner<br/>None</p>                |  | <p>51. Name of Carver<br/>None</p>         |  | <p>52. Name of Sculptor<br/>None</p>         |  |
| <p>53. Name of Potter<br/>None</p>            |  | <p>54. Name of Glassworker<br/>None</p>           |  | <p>55. Name of Paperhanger<br/>None</p>    |  | <p>56. Name of Wallpaperer<br/>None</p>      |  |
| <p>57. Name of Painter<br/>None</p>           |  | <p>58. Name of Decorator<br/>None</p>             |  | <p>59. Name of Florist<br/>None</p>        |  | <p>60. Name of Baker<br/>None</p>            |  |
| <p>61. Name of Confectioner<br/>None</p>      |  | <p>62. Name of Ice Cream Maker<br/>None</p>       |  | <p>63. Name of Butcher<br/>None</p>        |  | <p>64. Name of Grocer<br/>None</p>           |  |
| <p>65. Name of Druggist<br/>None</p>          |  | <p>66. Name of Apothecary<br/>None</p>            |  | <p>67. Name of Chemist<br/>None</p>        |  | <p>68. Name of Pharmacist<br/>None</p>       |  |
| <p>69. Name of Physician<br/>None</p>         |  | <p>70. Name of Surgeon<br/>None</p>               |  | <p>71. Name of Dentist<br/>None</p>        |  | <p>72. Name of Optician<br/>None</p>         |  |
| <p>73. Name of Electrician<br/>None</p>       |  | <p>74. Name of Plumber<br/>None</p>               |  | <p>75. Name of Carpenter<br/>None</p>      |  | <p>76. Name of Joiner<br/>None</p>           |  |
| <p>77. Name of Carver<br/>None</p>            |  | <p>78. Name of Sculptor<br/>None</p>              |  | <p>79. Name of Potter<br/>None</p>         |  | <p>80. Name of Glassworker<br/>None</p>      |  |
| <p>81. Name of Paperhanger<br/>None</p>       |  | <p>82. Name of Wallpaperer<br/>None</p>           |  | <p>83. Name of Painter<br/>None</p>        |  | <p>84. Name of Decorator<br/>None</p>        |  |
| <p>85. Name of Florist<br/>None</p>           |  | <p>86. Name of Baker<br/>None</p>                 |  | <p>87. Name of Confectioner<br/>None</p>   |  | <p>88. Name of Ice Cream Maker<br/>None</p>  |  |
| <p>89. Name of Butcher<br/>None</p>           |  | <p>90. Name of Grocer<br/>None</p>                |  | <p>91. Name of Druggist<br/>None</p>       |  | <p>92. Name of Apothecary<br/>None</p>       |  |
| <p>93. Name of Chemist<br/>None</p>           |  | <p>94. Name of Pharmacist<br/>None</p>            |  | <p>95. Name of Physician<br/>None</p>      |  | <p>96. Name of Surgeon<br/>None</p>          |  |
| <p>97. Name of Dentist<br/>None</p>           |  | <p>98. Name of Optician<br/>None</p>              |  | <p>99. Name of Electrician<br/>None</p>    |  | <p>100. Name of Plumber<br/>None</p>         |  |
| <p>101. Name of Carpenter<br/>None</p>        |  | <p>102. Name of Joiner<br/>None</p>               |  | <p>103. Name of Carver<br/>None</p>        |  | <p>104. Name of Sculptor<br/>None</p>        |  |
| <p>105. Name of Potter<br/>None</p>           |  | <p>106. Name of Glassworker<br/>None</p>          |  | <p>107. Name of Paperhanger<br/>None</p>   |  | <p>108. Name of Wallpaperer<br/>None</p>     |  |
| <p>109. Name of Painter<br/>None</p>          |  | <p>110. Name of Decorator<br/>None</p>            |  | <p>111. Name of Florist<br/>None</p>       |  | <p>112. Name of Baker<br/>None</p>           |  |
| <p>113. Name of Confectioner<br/>None</p>     |  | <p>114. Name of Ice Cream Maker<br/>None</p>      |  | <p>115. Name of Butcher<br/>None</p>       |  | <p>116. Name of Grocer<br/>None</p>          |  |
| <p>117. Name of Druggist<br/>None</p>         |  | <p>118. Name of Apothecary<br/>None</p>           |  | <p>119. Name of Chemist<br/>None</p>       |  | <p>120. Name of Pharmacist<br/>None</p>      |  |
| <p>121. Name of Physician<br/>None</p>        |  | <p>122. Name of Surgeon<br/>None</p>              |  | <p>123. Name of Dentist<br/>None</p>       |  | <p>124. Name of Optician<br/>None</p>        |  |
| <p>125. Name of Electrician<br/>None</p>      |  | <p>126. Name of Plumber<br/>None</p>              |  | <p>127. Name of Carpenter<br/>None</p>     |  | <p>128. Name of Joiner<br/>None</p>          |  |
| <p>129. Name of Carver<br/>None</p>           |  | <p>130. Name of Sculptor<br/>None</p>             |  | <p>131. Name of Potter<br/>None</p>        |  | <p>132. Name of Glassworker<br/>None</p>     |  |
| <p>133. Name of Paperhanger<br/>None</p>      |  | <p>134. Name of Wallpaperer<br/>None</p>          |  | <p>135. Name of Painter<br/>None</p>       |  | <p>136. Name of Decorator<br/>None</p>       |  |
| <p>137. Name of Florist<br/>None</p>          |  | <p>138. Name of Baker<br/>None</p>                |  | <p>139. Name of Confectioner<br/>None</p>  |  | <p>140. Name of Ice Cream Maker<br/>None</p> |  |
| <p>141. Name of Butcher<br/>None</p>          |  | <p>142. Name of Grocer<br/>None</p>               |  | <p>143. Name of Druggist<br/>None</p>      |  | <p>144. Name of Apothecary<br/>None</p>      |  |
| <p>145. Name of Chemist<br/>None</p>          |  | <p>146. Name of Pharmacist<br/>None</p>           |  | <p>147. Name of Physician<br/>None</p>     |  | <p>148. Name of Surgeon<br/>None</p>         |  |
| <p>149. Name of Dentist<br/>None</p>          |  | <p>150. Name of Optician<br/>None</p>             |  | <p>151. Name of Electrician<br/>None</p>   |  | <p>152. Name of Plumber<br/>None</p>         |  |
| <p>153. Name of Carpenter<br/>None</p>        |  | <p>154. Name of Joiner<br/>None</p>               |  | <p>155. Name of Carver<br/>None</p>        |  | <p>156. Name of Sculptor<br/>None</p>        |  |
| <p>157. Name of Potter<br/>None</p>           |  | <p>158. Name of Glassworker<br/>None</p>          |  | <p>159. Name of Paperhanger<br/>None</p>   |  | <p>160. Name of Wallpaperer<br/>None</p>     |  |
| <p>161. Name of Painter<br/>None</p>          |  | <p>162. Name of Decorator<br/>None</p>            |  | <p>163. Name of Florist<br/>None</p>       |  | <p>164. Name of Baker<br/>None</p>           |  |
| <p>165. Name of Confectioner<br/>None</p>     |  | <p>166. Name of Ice Cream Maker<br/>None</p>      |  | <p>167. Name of Butcher<br/>None</p>       |  | <p>168. Name of Grocer<br/>None</p>          |  |
| <p>169. Name of Druggist<br/>None</p>         |  | <p>170. Name of Apothecary<br/>None</p>           |  | <p>171. Name of Chemist<br/>None</p>       |  | <p>172. Name of Pharmacist<br/>None</p>      |  |
| <p>173. Name of Physician<br/>None</p>        |  | <p>174. Name of Surgeon<br/>None</p>              |  | <p>175. Name of Dentist<br/>None</p>       |  | <p>176. Name of Optician<br/>None</p>        |  |
| <p>177. Name of Electrician<br/>None</p>      |  | <p>178. Name of Plumber<br/>None</p>              |  | <p>179. Name of Carpenter<br/>None</p>     |  | <p>180. Name of Joiner<br/>None</p>          |  |
| <p>181. Name of Carver<br/>None</p>           |  | <p>182. Name of Sculptor<br/>None</p>             |  | <p>183. Name of Potter<br/>None</p>        |  | <p>184. Name of Glassworker<br/>None</p>     |  |
| <p>185. Name of Paperhanger<br/>None</p>      |  | <p>186. Name of Wallpaperer<br/>None</p>          |  | <p>187. Name of Painter<br/>None</p>       |  | <p>188. Name of Decorator<br/>None</p>       |  |
| <p>189. Name of Florist<br/>None</p>          |  | <p>190. Name of Baker<br/>None</p>                |  | <p>191. Name of Confectioner<br/>None</p>  |  | <p>192. Name of Ice Cream Maker<br/>None</p> |  |
| <p>193. Name of Butcher<br/>None</p>          |  | <p>194. Name of Grocer<br/>None</p>               |  | <p>195. Name of Druggist<br/>None</p>      |  | <p>196. Name of Apothecary<br/>None</p>      |  |
| <p>197. Name of Chemist<br/>None</p>          |  | <p>198. Name of Pharmacist<br/>None</p>           |  | <p>199. Name of Physician<br/>None</p>     |  | <p>200. Name of Surgeon<br/>None</p>         |  |



8624

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>MEYERSDALE</b>           |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>29 DAYS</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>   |                                  | d. STREET ADDRESS<br><b>RR RT. #4 75x-3</b>   |                                      |
| 3. NAME OF DECEASED<br>(Type or print) <b>MRS. CLARA E. PORTER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST 28</b> Day <b>19</b> Year <b>59</b>   |                                      |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/16/1913</b> |
| 9. AGE (In years last birthday) yrs. <b>46</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |                                      |
| 13. FATHER'S NAME<br><b>GEORGE TRESSLER</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>SUSAN BITTNER</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                      |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                                  | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Cardiac arrest</b><br><b>420.0</b> DUE TO <b>Complete Heart Block with low-ventricular rhythm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>anticoagulant Heart Disease Coronary</b><br>DUE TO <b>5 years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 month</b>  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>19 Aug. 1959</b> to <b>28 Aug. 1959</b> , that I last saw the deceased alive on <b>26 Aug. 1959</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.  |                                  |   |                                      |
| ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>172 S. Centre St. 28 Aug. 59</b>   |                                      |
| PHYSICIAN'S NAME (Type) <b>DR. W.A. VAN ORMER</b>  |                                  | <b>CUMBERLAND, MD.</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8/31/59</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>White Oak Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>RR #4 Meyersdale, Pa</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Konhaus Funeral Home</b>  |                                  | 24. REC'D BY REGISTRAR<br>DATE <b>SEP 9 '59</b>   |                                      |
| ADDRESS<br><b>Meyersdale</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |                                      |

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

8834

CERTIFICATE OF DEATH

8834

1





1  
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8625  
CERTIFICATE OF DEATH

09776

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>65 years</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>711 Louisiana Ave.</b>  |                                  | d. STREET ADDRESS<br><b>711 Louisiana Ave.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>ELLEN D. REITMEIER</b>   |                                  | 4. DATE OF DEATH <b>Aug. 9, 1959</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 23, 1876</b> |
| 9. AGE (In years last birthday) <b>83</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Vale Summit, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Luke Delaney</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Baxter</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(If yes, no, or unknown) <b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Mrs. Mary Conroy</b>   |                                  | Address<br><b>Cumberland, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b><br>DUE TO (c) _____                              |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>22 HRS</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>AUG 8</b> , 19 <b>59</b> , to <b>AUG 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>AUG 9</b> , 19 <b>59</b> , and that death occurred at <b>3:00 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>William P. James M.D.</b> <b>8.14.59</b> |                                  |   |  |
| ACTUAL SIGNATURE <b>William P. James</b> M.D.  |                                  |   |  |
| PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M.D.</b> <b>441 N. CENTRE ST., CUMBERLAND, MD</b>   |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 12, 1959</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patricks Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Kight</b>   |                                  | ADDRESS<br><b>Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 10 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Hines</b>   |  |







8626

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  | c. LENGTH OF STAY IN 1b<br><b>X Rt. 1, Cumberland</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ralph</b> Middle <b>J.</b> Last <b>Rice</b>  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>3</b> Year <b>1959</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/3, -1896</b>                                  |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>W. Va. Huntington</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Augustus Rice</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Hanna Daniels</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>705-05-4831</b>   |   |
| 17. INFORMANT<br><b>Wife</b>   |  | Address<br><b>Rt. 1, Cumberland, Md</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>July 26, 1959</b> , to <b>7-3</b> , 1959, that I last saw the deceased alive on <b>Aug 3</b> , 1959, and that death occurred at <b>8:55 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>441 N. Center St., Cumberland, Md.</b> DATE SIGNED <b>8-5-59</b>   |  |   |   |
| ACTUAL SIGNATURE <b>William P. Scarpelli</b> M.D.  |  |   |   |
| PHYSICIAN'S NAME (Type) <b>James, Wm. T., M.D.</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Aug. 6, 1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br><b>AUG 6 1959</b><br>DATE  |   |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Kneass</b>  |   |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 9/58

CERTIFICATE OF DEATH

8838

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8627

CERTIFICATE OF DEATH

Reg. Dist. No.

08609

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b><br>MIDDLE  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b><br>b. COUNTY <b>ALLEGANY</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>3 DAYS</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>R.</b> Last <b>RIGGS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>4</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DECEMBER 28 1872-86</b> |
| 9. AGE (In years lost birthday) yrs.<br><b>86</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED LABORER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mining Co.</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>ARKANSAS-FORTSMITH</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JESSE RIGGS</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>FRANCES MC ALISTER</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |  |
| 17. ADDRESS<br><b>WARWICK &amp; MEMORIAL AVENUE</b>   |                                  | 18. ADDRESS<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Thrombosis</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.<br>(b) <b>Myocardial Infarction</b> DUE TO<br>(c) <b>Atherosclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks</b><br><b>3 yrs</b><br><b>15 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br>19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Jan 4 1959</b> , to <b>Aug 4 1959</b> , that I last saw the deceased alive on <b>Aug 4 1959</b> , and that death occurred at <b>11:25 PM</b> , from the causes and on the date stated above.   |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Clay Durrett</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>236 W. 1st Cumberland Md</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. CLAY DURRETT</b>  |                                  | DATE SIGNED<br><b>8/5/59</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Aug. 8, 1959</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Herman Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |                                  | ADDRESS<br><b>Cumberland, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 10 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kline</b>  |  |

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

CLEVELAND

3 DAYS

CLEVELAND

MEMORIAL HOSPITAL

255 VIRGINIA AVENUE

CHARLES R.

RIDGE

WHITE

MALE

WHITE

DECEASED 28

RETIRED

FRANCIS

2555 RIDGE

MEMORIAL HOSPITAL - CLEVELAND

2555 VIRGINIA AVENUE

DR. CLAY DUNN

CLEVELAND, OH.

CLEVELAND, OH.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08610

8628 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GLADYS Elaine RINGLER</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>AUGUST 19 19 59</b>  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUGUST 14, 1926</b> |
| 9. AGE (In years last birthday)<br><b>33</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Elba, Alabama</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>THOMAS CUTTS</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MAE B. BATSON</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>WARWICK &amp; MEMORIAL AVENUE</b><br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>651.0</b> <b>Abortion, spontaneous, Septic -</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with Hemorrhagic nephritis and Uremia</b><br>DUE TO (c) <b>approx 4 days</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>approx 1 week</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug 17</b> , 19 <b>59</b> , to <b>Aug 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 19</b> , 19 <b>59</b> , and that death occurred at <b>6:05 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>Aug 20, 1959</b><br>ACTUAL SIGNATURE <b>DR. W. FAW</b> M.D. <b>Cumberland Md</b><br>PHYSICIAN'S NAME (Type) <b>DR. W. FAW</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Aug. 21, 1959</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Cem.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 24 '59</b>   |  |
| ADDRESS<br><b>Cumberland, Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kinn</b>   |  |

# CERTIFICATE OF DEATH

DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.  
 DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.  
 DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.

DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.  
 DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.  
 DECEASED: CLAYTON, CLAYTON  
 SEX: FEMALE  
 RACE: WHITE  
 DATE OF BIRTH: AUGUST 14, 1910  
 PLACE OF BIRTH: WYOMING  
 US BIRTH: U.S.A.



8629

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>2 HRS. 24 MIN.</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HARRY</b> Middle <b>BERNARD</b> Last <b>RUSSELL</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>8</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>SEPT. 6, 1906</b>                     |  |
| 9. AGE (In years last birthday)<br><b>52</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>52</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  | 11. IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Celanese Corp.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b> |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |  |  |  |
| 17. ADDRESS (Street, city or town, state)<br><b>WARWICK &amp; MEMORIAL AVENUE</b>   |  |  |  | 18. ADDRESS (Street, city or town, state)<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO<br>(c) <b>ARTERIOSCLEROSIS</b> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA DUE BLOOD LOSS FROM GASTRIC CONGESTION</b>  |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>0</b> p. m. <b>19</b>   |  |  |  |   |  |  |  |
| 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |   |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>1959</b> , to <b>AUG 8, 1959</b> , that I last saw the deceased alive on <b>AUG 8, 1959</b> , and that death occurred at <b>12:54 A.M.</b> , from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| ADDRESS (Street, city or town, state)<br><b>59 GREENE ST CUMBERLAND, MD</b>   |  |  |  |   |  |  |  |
| DATE SIGNED <b>8/8/59</b>   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Allevsman</b> M.D.  |  |  |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>DR. S.G. WEISMAN</b>   |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  |   |  |  |  |
| 22b. DATE THEREOF<br><b>8/10/59</b>   |  |  |  |   |  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |  |  |  |   |  |  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>  |  |  |  |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>  |  |  |  |   |  |  |  |
| ADDRESS<br><b>Cumberland, Md.</b>   |  |  |  |   |  |  |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE AUG 11 '59</b>   |  |  |  |   |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>  |  |  |  |   |  |  |  |

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

8028

ALLEGANY

WYANDOT

WYANDOT

2 1/2 SW 1/4

WYANDOT

WYANDOT

1 1/2 E 1/2 SW 1/4

HARRY

WYANDOT

WYANDOT

WHITE

WYANDOT

WYANDOT

WYANDOT

WYANDOT

WYANDOT

WYANDOT

WYANDOT

WYANDOT

1

8630

## CERTIFICATE OF DEATH

08612

Reg. Dist. No.

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Allegany</u> MARYLAND  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>  |  |   |   | c. LENGTH OF STAY IN 1b<br><u>83 Yrs</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>1722 Bedford Street</u>   |  |   |   | d. STREET ADDRESS<br><u>1722 Bedford Street</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Walter</u> Middle <u>P</u> Last <u>Schlund</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>29</u> Year <u>1959</u>   |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>                                  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>April 27, 1876</u>   |  |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.  |  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ |   | IF UNDER 24 HRS.<br>Months _____ Days _____ Hours _____ Min. _____   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Florist.</u>   |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>John C. Schlund</u>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Mary Goor</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><u>446 N. Centre Street, Mrs. Louise Zimmerle, Cumberland, Maryland</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)          |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour _____ p. m. _____ 19 _____   |  |   | 20d. INJURY OCCURRED<br>While <input checked="" type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>3/27/77</u> , 19____, to <u>8/29/59</u> , 19____, that I last saw the deceased alive on <u>8/29/59</u> , 19____, and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>8/30/59</u><br>ACTUAL SIGNATURE <u>[Signature]</u> M.D. _____<br>PHYSICIAN'S NAME (Type) _____   |  |   |   |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>8/31/59</u>                               |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Trinity Lutheran Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland Maryland</u>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Ruth E. Silcox</u>  |  |   |   | ADDRESS<br><u>Cumberland Maryland</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>SEP 1 '59</u>  |  |
|  |  |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>   |  |   |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8632 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WILEY FORD</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LULA</b> Middle <b>SHOCKEY</b> Last <b>SHOCKEY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>29</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIAGE STATUS<br><del>MARRIED</del> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 8, 1882</b> |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>EDWARD BISE R (DECEASED)</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE FULTZ (DECEASED)</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>PTS. CHART</b>   |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix with Metastases</b><br><b>153.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>January 8, 1959</b> to <b>8-29-1959</b> that I last saw the deceased alive on <b>8-28-1959</b> and that death occurred at <b>12:45 AM</b> from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>James T. Johnson, Jr.</b>   |                                  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>16 GREENE ST. CUMBERLAND, MARYLAND. 10-28-59</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>JAMES T. JOHNSON, JR., M.D.</b>  |                                  | <b>16 GREENE ST., CUMBERLAND, MARYLAND.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 22b. DATE THEREOF<br><b>8-31-59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Indian Mound Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Romney, Hampshire, W.Va.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Mary L. Combs</b>   |                                  | ADDRESS<br><b>Romney, W. Va.</b>   |   |
| 24a. REC'D BY REGISTRAR<br><b>SEP 2 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Frank</b>  |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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|                       |  |                      |  |                        |  |
|-----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED      |  | DATE OF BIRTH        |  | PLACE OF BIRTH         |  |
| JAMES A. JONES        |  | JAN 1 1921           |  | JACKSON, MISSISSIPPI   |  |
| SEX                   |  | AGE                  |  | OCCUPATION             |  |
| MALE                  |  | 39                   |  | FARMER                 |  |
| MARRIED               |  | DATE OF MARRIAGE     |  | PLACE OF MARRIAGE      |  |
| YES                   |  | JAN 15 1945          |  | JACKSON, MISSISSIPPI   |  |
| CAUSE OF DEATH        |  | MANNER OF DEATH      |  | PLACE OF DEATH         |  |
| HEART DISEASE         |  | NATURAL              |  | JACKSON, MISSISSIPPI   |  |
| DATE OF DEATH         |  | PLACE OF DEATH       |  | SIGNATURE OF PHYSICIAN |  |
| JAN 15 1960           |  | JACKSON, MISSISSIPPI |  | J. A. JONES            |  |
| SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESS |  | SIGNATURE OF PHYSICIAN |  |
| JAMES A. JONES        |  | J. A. JONES          |  | J. A. JONES            |  |

*[Faint, illegible text, likely bleed-through from the reverse side of the document]*



## 8633 CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |   |  |   |  |
|--|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>4 Yrs.</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b>                                    |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>300 Avirett Avenue</b>  |                                  |   |   | d. STREET ADDRESS<br><b>300 Avirett Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>Thomas</b> Last <b>Sleeman</b>   |                                  |   |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>1st</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 31st, 1873</b> | 9. AGE (In years last birthday)<br><b>86</b> yrs.   | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HRS.<br>Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Engineer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pa. &amp; Lake Erie R.R.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>William Sleeman</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret McFarland</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |   | 17. ADDRESS<br><b>300 Avirett Ave.,<br/>Mrs. Ida Cookerly, Cumberland, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Esophagus</b><br><b>150X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>one month</b> |                                  |   |   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month _____ Day _____ Year <b>19</b><br>Hour o. m. _____ p. m. _____  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that I attended the deceased from <b>6/29</b> , 19 <b>59</b> , to <b>8/1</b> , 19 <b>59</b> that I last saw the deceased alive on <b>8/1</b> , 19 <b>59</b> , and that death occurred at <b>4:00 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>36 Greene Street,</b> DATE SIGNED _____<br>ACTUAL SIGNATURE <b>Earl R. Paul</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>Earl R. Paul,</b> M.D. <b>Cumberland, Md.</b>   |                                  |   |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8-4-59</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Md.</b>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Durst, Frostburg, Md.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 6 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |  |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8833 CERTIFICATE OF DEATH

Combsland

300 Atlantic Avenue

John

White

Not. Englehart

William Brown

Combsland

300 Atlantic Avenue

John

White

Not. Englehart

William Brown

Combsland, New York, N.Y.

At the end of the

At the end of the

At the end of the

At the end of the

## 8634 CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |                                  |  |  |  |  |                                  |
|---|--|----------------------------------|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |  |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |  |                                  |  | c. LENGTH OF STAY IN 1b <b>1 DAY</b>   |  |  |                                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>   |  |                                  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |                                  |
| 3. NAME OF DECEASED (Type or print) <b>ALICE Angela SMALL</b>   |  |                                  |  | 4. DATE OF DEATH <b>AUGUST 20 19 59</b>  |  |  |                                  |
| 5. SEX <b>FEMAL</b>   |  | 6. COLOR OR RACE <b>WHITE</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>APRIL 6, 1896</b>                                    |                                  |
| 9. AGE (In years last birthday) <b>63</b> yrs.  |  | IF UNDER 1 YEAR Months Days      |  | IF UNDER 24 HRS. Hours Min.  |  |  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                |                                  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |                                  |  |  |  |  |                                  |
| 13. FATHER'S NAME <b>John H. Harvey</b>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Ellen Shea</b>  |  |  |                                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |                                  |  | 16. SOCIAL SECURITY NO. <b>PATIENTS CHART.</b>   |  |  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  |
| 20f. (City or town) (County) (State)  |  |                                  |  |  |  |  |                                  |
| 21. I certify that I attended the deceased from <b>8/18</b> , 19 <b>59</b> , to <b>8/20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/19</b> , 19 <b>59</b> , and that death occurred at <b>2:55AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>N. CENTRE ST., CUMBERLAND, MD.</b> DATE SIGNED <b>8/20/59</b>  |  |                                  |  |  |  |  |                                  |
| ACTUAL SIGNATURE <b>Leo H. Ley, Jr.</b> M.D.  |  |                                  |  |  |  |  |                                  |
| PHYSICIAN'S NAME (Type) <b>LEO H. LEY, JR., MD.</b>   |  |                                  |  |  |  |  |                                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>8/22/59</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b> |                                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b> <b>Cumberland Maryland</b>   |  |                                  |  | 24a. REC'D BY REGISTRAR <b>AUG 24 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                        |                                  |

100-100000

100-100000



8635

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b> Route #1  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ira</b> Middle <b>A.</b> Last <b>Smith</b>   |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>10</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>          | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 7, 1929</b>                                      |
| 9. AGE (In years lost birthday)<br><b>29</b> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>29</b> Min.                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>McIntyre Gafage</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Ira William Smith</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Edith Lease</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>213-24-5618</b>   |  |
| 17. INFORMANT<br><b>Mrs. Lillian Smith</b>   |   | 18. ADDRESS<br><b>Rt. 1 Valley Road Cumberland, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pleural Empyema, ac. pericarditis &amp; pneumonia</b> 5-6 days<br>550.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Subphrenic Abscess</b> 6 days<br>DUE TO (c) <b>Rupt. appendix</b> 7 days |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. _____ 19  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   |   | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that I attended the deceased from <b>Aug 7, 1959</b> , to <b>Aug 10, 1959</b> , that I last saw the deceased alive on <b>Aug 10, 1959</b> , and that death occurred at <b>10:15 P</b> M, from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><b>A. J. Mirkin</b>  |   | ADDRESS (Street, city or town, state)<br><b>115 So. Centre Street, Cumberland, Md.</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>A. J. Mirkin, M.D.</b>   |   | DATE SIGNED<br><b>8/12 59</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Aug. 13, 1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lease Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cresaptown, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Chas. E. Kneass</b>  |  |

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

65317

MAINTENANCE OF RECORDS - BUREAU OF

CENTRAL OFFICE OF DEATH

65317

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

REMARKS

DATE OF DEATH



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8636

CERTIFICATE OF DEATH

08618

Reg. Dist. No.

|  |                                  |   |                                     |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7/29/59</b>   |                                     |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Patrick</b> Middle <b>J.</b> Last <b>Stakem</b>  |                                  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>1,</b> Year <b>1959</b>  |                                     |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2/8/1885</b> |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Bowling Alley Proprietor</b>                         |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Paradise, Maryland</b>  |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>U. S. A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>John Stakem</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Cullen</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>212-32-8337</b>   |                                     |
| 17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b><br>422.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b><br>DUE TO<br>(c) <b>Cerebral Arteriosclerosis</b> |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Parkinsons Disease</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b>   |                                     |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  | 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                     |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                     |
| 20f. (City or town) (County) (State)   |                                  | 21. I certify that I attended the deceased from <b>7/29/59</b> , 19____, to <b>8/1/59</b> , 19____, that I last saw the deceased alive on <b>7/31/59</b> , 19____, and that death occurred on <b>8/1/59</b> , 19____, at <b>5:35 A.M.</b> , from the causes and on the date stated above.   |                                     |
| ADDRESS (Street, city or town, state)<br><b>49 Greene St.,</b>   |                                  | DATE SIGNED<br><b>8/1/59</b>  |                                     |
| ACTUAL SIGNATURE<br><b>James E. McLean</b> M.D.  |                                  | PHYSICIAN'S NAME (Type)<br><b>Dr. James E. McLean</b>   |                                     |
| Cumberland, Md.  |                                  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                     |
| 22b. DATE THEREOF<br><b>8/4/59</b>   |                                  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul's</b>   |                                     |
| 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>   |                                  | 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>  |                                     |
| ADDRESS<br><b>Cumberland, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>AUG 5 '59</b>   |                                     |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |                                  |   |                                     |

CERTIFICATE OF DEATH

8435

Allegany Maryland

Allegany

Allegany

Chesapeake

7/29/22

Chesapeake

711 Chesapeake St.

Allegany County Jail

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

8656

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                       |   |  |
|---|---------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Midland</b>  |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Midland</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                       | d. STREET ADDRESS   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>THOMAS E. STAKEM</b>  |                                       | 4. DATE OF DEATH<br>Month <b>8/24/1959</b> Day <b>19</b> Year <b>19</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>      | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>2/23/1878</b>                                   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.   |                                       | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Self Employed</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Lonaconing, MD.</b>   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Patrick Stakem</b>  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Esther M. Cavanaugh</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                       | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Patrick Stakem, Cumberland, MD.</b>   |                                       | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial insufficiency</b><br>DUE TO (c) <b>arterio sclerosis</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>1 year</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                       | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Aug 20, 1959</b> to <b>Aug 24, 1959</b> , that I last saw the deceased alive on <b>Aug 22, 1959</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above. |                                       |   |  |
| ACTUAL SIGNATURE<br><b>Wm Mc Lane M.D.</b>  |                                       | ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Aug 23 1959</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Wm Mc Lane M.D.</b>   |                                       |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8/26/1959</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michaels Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>GEORGE EICHORN</b>   |                                       | ADDRESS<br><b>LONA CONING, MD.</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 28 59</b>  |                                       | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hous</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## References

1  
Page 4  
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8637 Items 8, 10 Film G246 8-11-59 et  
CERTIFICATE OF DEATH

08620

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>4 DAYS</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL<br/>MEMORIAL &amp; WARWICK AVES.,</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>T.</b> Last <b>STOTLEMYER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>1</b> Year <b>19 59</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 27, 1886</b>   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b>   | 11. IF UNDER 24 HRS.<br>Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Not given</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MARYLAND</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOSEPH B. STOTLEMYER</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CHRISTINA ZEIGLAR</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>110K.</b><br>(c)   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>7-28, 1959</b> , to <b>8-1, 1959</b> , that I last saw the deceased alive on <b>8-1, 1959</b> , and that death occurred at <b>10:00AM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>8-1-59</b><br>ACTUAL SIGNATURE <b>W.F. Williams</b> M.D. <b>W.F. Williams</b><br>PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>8.4.59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Piney Plains Methodist</b>   |                                  | 22d. LOCATION (City, town, or county) (State) <b>Little Orleans Allegany Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard F. Stone</b>  |                                  | ADDRESS <b>Hancock Md</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>AUG 6 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |  |



10-531

CERTIFICATE OF DEATH

86854

ALLIANCE

WYLAND

ALLIANCE

LITTLE GREEN

WYLAND

WYLAND

GENERAL A. MARSHALL

AUGUST

STOLEN

STOLEN

18

JUNE 27

WHITE

MALE

U.S.A.

MARYLAND

CHRISTIAN ZEPHER

JOHN B. STOLEN

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL



W.F. WILLIAMS

INDEXED, SERIALIZED, FILED

U.S. DEPT. OF JUSTICE



8651

## CERTIFICATE OF DEATH

08621

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>  |  | c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>141 Maple St.</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>William</b> Last <b>Timmons</b>  |  | 4. DATE OF DEATH Month <b>August</b> Day <b>4th</b> Year <b>1959</b>   |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Oct. 25th, 1871</b>                             |
| 9. AGE (In years last birthday) <b>87</b> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Mail Carrier</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>Joseph Timmons</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Caroline Smith</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO. <b>215-18-8874</b>   |   |
| 17. INFORMANT Address <b>Mrs. Sarah Cross, 141 Maple St., F'bg. Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach - 151X</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 2-7</b>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis of the Heart Disease</b>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that I attended the deceased from <b>8/2</b> , 19 <b>57</b> , to <b>8/4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/4/59</b> , 19 <b>59</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above.                                     |  |  |   |
| ACTUAL SIGNATURE <b>Martin M. Rothstein</b> M.D.   |  | ADDRESS (Street, city or town, state) <b>48 BROADWAY</b> DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>  |  | <b>FROSTBURG - MD.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>8-7-59</b>  | 22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>  | 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>  |  | 24a. REC'D BY REGISTRAR <b>AUG 10 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>  |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7-11-0

8638

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |                                    |  |   |   |  |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Allegany</u> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>                    |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><u>4 yrs</u>  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Bedford, Road Rt #3</u>  |                                  |   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) <u>John James Thomas Turner</u>   |                                  |   |                                    | 4. DATE OF DEATH <u>August 6 19 59</u>   |   |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/20/97</u> | 9. AGE (In years last birthday)<br><u>62</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>   |                                  |   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Am. Can Co.</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Penna.</u>              |  |
| 13. FATHER'S NAME<br><u>Emanuel C. Turner</u>   |                                  |   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |                                  |   |                                    | 16. SOCIAL SECURITY NO.<br><u>214-05-9105</u>  |   |   |  |
| 17. INFORMANT<br><u>Mrs. Fred Zembower</u>  |                                  |   |                                    | Address<br><u>Bedford, Rd. Cumberland, Md.</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u><br>DUE TO (c) _____ |                                  |   |                                    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 minutes</u>                   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |                                    |  |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                    |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. _____ p. m. _____ 19 _____   |                                  |   |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) _____ (County) _____ (State) _____  |                                  |   |                                    |  |   |   |  |
| 21. I certify that I attended the deceased from <u>8/12/57</u> , 19____, to <u>8/6/59</u> , 19____, that I last saw the deceased alive on <u>8/4/59</u> , 19____, and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.   |                                  |   |                                    |  |   |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D.  |                                  |   |                                    | ADDRESS (Street, city or town, state) <u>122 S. Centre Street</u>  |   |   |  |
| DATE SIGNED <u>8-6-59</u>   |                                  |   |                                    |  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>Richard J. Williams, M.D.</u>  |                                  |   |                                    | Cumberland, Maryland   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>8/8/59</u>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Zion Memorial Park</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Md.</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>H. Lee Silcox</u>  |                                  |   |                                    | ADDRESS<br><u>Cumberland, Md.</u>  |   | 24a. REC'D BY REGISTRAR<br>DATE <u>AUG 10 '59</u>                       |  |
|   |                                  |   |                                    | 24b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Form No. 10

|  |  |  |  |
|--|--|--|--|
| <p>1. Name of deceased: <u>JOHN DOE</u></p>          |  | <p>2. Sex: <u>Male</u></p>                                     |  |
| <p>3. Date of birth: <u>1900-01-01</u></p>           |  | <p>4. Place of birth: <u>NEW YORK</u></p>                      |  |
| <p>5. Date of death: <u>1950-01-01</u></p>           |  | <p>6. Place of death: <u>NEW YORK</u></p>                      |  |
| <p>7. Cause of death: <u>Heart Disease</u></p>       |  | <p>8. Manner of death: <u>Natural</u></p>                      |  |
| <p>9. Signature of physician: <u>[Signature]</u></p> |  | <p>10. Signature of registrar: <u>[Signature]</u></p>          |  |
| <p>11. Date of registration: <u>1950-01-01</u></p>   |  | <p>12. Place of registration: <u>NEW YORK</u></p>              |  |
| <p>13. Name of informant: <u>JOHN DOE</u></p>        |  | <p>14. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>15. Name of informant: <u>JOHN DOE</u></p>        |  | <p>16. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>17. Name of informant: <u>JOHN DOE</u></p>        |  | <p>18. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>19. Name of informant: <u>JOHN DOE</u></p>        |  | <p>20. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>21. Name of informant: <u>JOHN DOE</u></p>        |  | <p>22. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>23. Name of informant: <u>JOHN DOE</u></p>        |  | <p>24. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>25. Name of informant: <u>JOHN DOE</u></p>        |  | <p>26. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>27. Name of informant: <u>JOHN DOE</u></p>        |  | <p>28. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>29. Name of informant: <u>JOHN DOE</u></p>        |  | <p>30. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>31. Name of informant: <u>JOHN DOE</u></p>        |  | <p>32. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>33. Name of informant: <u>JOHN DOE</u></p>        |  | <p>34. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>35. Name of informant: <u>JOHN DOE</u></p>        |  | <p>36. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>37. Name of informant: <u>JOHN DOE</u></p>        |  | <p>38. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>39. Name of informant: <u>JOHN DOE</u></p>        |  | <p>40. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>41. Name of informant: <u>JOHN DOE</u></p>        |  | <p>42. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>43. Name of informant: <u>JOHN DOE</u></p>        |  | <p>44. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>45. Name of informant: <u>JOHN DOE</u></p>        |  | <p>46. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>47. Name of informant: <u>JOHN DOE</u></p>        |  | <p>48. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>49. Name of informant: <u>JOHN DOE</u></p>        |  | <p>50. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>51. Name of informant: <u>JOHN DOE</u></p>        |  | <p>52. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>53. Name of informant: <u>JOHN DOE</u></p>        |  | <p>54. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>55. Name of informant: <u>JOHN DOE</u></p>        |  | <p>56. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>57. Name of informant: <u>JOHN DOE</u></p>        |  | <p>58. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>59. Name of informant: <u>JOHN DOE</u></p>        |  | <p>60. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>61. Name of informant: <u>JOHN DOE</u></p>        |  | <p>62. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>63. Name of informant: <u>JOHN DOE</u></p>        |  | <p>64. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>65. Name of informant: <u>JOHN DOE</u></p>        |  | <p>66. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>67. Name of informant: <u>JOHN DOE</u></p>        |  | <p>68. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>69. Name of informant: <u>JOHN DOE</u></p>        |  | <p>70. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>71. Name of informant: <u>JOHN DOE</u></p>        |  | <p>72. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>73. Name of informant: <u>JOHN DOE</u></p>        |  | <p>74. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>75. Name of informant: <u>JOHN DOE</u></p>        |  | <p>76. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>77. Name of informant: <u>JOHN DOE</u></p>        |  | <p>78. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>79. Name of informant: <u>JOHN DOE</u></p>        |  | <p>80. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>81. Name of informant: <u>JOHN DOE</u></p>        |  | <p>82. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>83. Name of informant: <u>JOHN DOE</u></p>        |  | <p>84. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>85. Name of informant: <u>JOHN DOE</u></p>        |  | <p>86. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>87. Name of informant: <u>JOHN DOE</u></p>        |  | <p>88. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>89. Name of informant: <u>JOHN DOE</u></p>        |  | <p>90. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>91. Name of informant: <u>JOHN DOE</u></p>        |  | <p>92. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>93. Name of informant: <u>JOHN DOE</u></p>        |  | <p>94. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>95. Name of informant: <u>JOHN DOE</u></p>        |  | <p>96. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>97. Name of informant: <u>JOHN DOE</u></p>        |  | <p>98. Address of informant: <u>123 Main St, New York</u></p>  |  |
| <p>99. Name of informant: <u>JOHN DOE</u></p>        |  | <p>100. Address of informant: <u>123 Main St, New York</u></p> |  |

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8639

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MARYLAND</b><br><b>ALLEGANY</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY                              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>20hrs 49min</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL-WARWICK &amp; MEMORIAL</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Paul</b> Middle <b>FRANKLIN</b> Last <b>TWIGG</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>13</b> Year <b>1959</b>  |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><b>AUGUST 12, 1959.</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>20</b>  |  | IF UNDER 1 YEAR<br>Months <b>49</b>       |  | IF UNDER 24 HRS.<br>Days <b>19</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Infant</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND Cumberland</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>DONALD E. TWIGG</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ARLENE E. MC DONALD</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| INFORMANT   |  |   |  | Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra Cranial Edema due to Cerebral Anoxia</b><br><b>760.0</b> DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>12 Aug 1959</b> to <b>13 Aug 1959</b> , that I last saw the deceased alive on <b>13 Aug 1959</b> , and that death occurred at <b>5:30 A</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Bedford St. Cumberland, Md.</b><br>DATE SIGNED <b>13 Aug 59</b><br>ACTUAL SIGNATURE <b>F. B. Whitworth</b> M.D. <b>Cumberland Md</b><br>PHYSICIAN'S NAME (Type) <b>DR. F.B. WHITWORTH</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Aug. 14, 1959</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Lawn Mem. Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>AUG 17 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>William E. Turner</b>                       |  |

2060223XV 3

# CERTIFICATE OF DEATH

8639

ALLIANCE

CLUBBING

MEMORIAL HOSPITAL-WARWICK & MEMPHIS

THIRDS

1943

MALE WHITE

DECEASED ABOUT 12, 1943

MEMPHIS, TENNESSEE, U.S.A.

WILLIAM E. MC DONALD

DOUGLAS E. THUR

MEMORIAL HOSPITAL, MEMPHIS, TENN.

MEMPHIS, TENNESSEE

MEMPHIS, TENNESSEE

JOHN A. THUR, DOUGLAS E. THUR



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08624

8640

# CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>13 weeks</b>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Warnick</b> Last <b>Warnick</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>22</b> Year <b>1959</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/31, -1873.</b>                                     |   |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |   |   |
| 13. FATHER'S NAME<br><b>Thomas McBride</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rachel McMasters</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address <b>Son Lester Same as pt.</b>  |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, multiple</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c) <b>Generalized visceral failure</b> |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mo.</b><br><b>10 yr.</b><br><b>2 mo.</b>                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Advanced age</b>  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/><br><b>none</b>                                 |  |   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |  |   |  | 20f. (City or town) (County) (State)   |  |   |   |
| 21. I certify that I attended the deceased from <b>May 14, 1959</b> to <b>August 23, 1959</b> , that I lost the deceased alive on <b>August 23, 1959</b> , and that death occurred at <b>4:50 PM</b> from the causes and on the date stated above.  |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE <b>James T. Hallinan</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>140 Bedford Street</b> DATE SIGNED <b>8/25/59</b>   |  |   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. J.P. Hallinan</b>  |  |   |  | <b>Cumberland, Maryland.</b>   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>8/26/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b>   |  |   |  | ADDRESS<br><b>Cumberland Maryland</b>  |  |   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 28 '59</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>   |  |   |   |

062

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8640

CLINICAL OF DEATH

1947

1. Name of patient: [illegible]  
2. Age: [illegible]  
3. Sex: [illegible]  
4. Date of birth: [illegible]  
5. Date of admission: [illegible]  
6. Referring physician: [illegible]  
7. Presenting complaint: [illegible]  
8. History of present illness: [illegible]  
9. Past medical history: [illegible]  
10. Family history: [illegible]  
11. Social history: [illegible]  
12. Physical examination: [illegible]  
13. Laboratory studies: [illegible]  
14. Radiology: [illegible]  
15. Pathology: [illegible]  
16. Microbiology: [illegible]  
17. Immunology: [illegible]  
18. Special studies: [illegible]  
19. Summary: [illegible]  
20. Diagnosis: [illegible]  
21. Prognosis: [illegible]  
22. Treatment: [illegible]  
23. Follow-up: [illegible]

1  
TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8641  
CERTIFICATE OF DEATH

08625

Reg. Dist. No.

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Allegany</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Allegany</b>        |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>7/8/59</b>  |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>   |                                  | d. STREET ADDRESS<br><b>Route #1</b>  |                                      |
| 3. NAME OF DECEASED (Type or print)<br><b>James William Warnick</b>  |                                  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>18</b> Year <b>1959</b>  |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/26/1876</b> |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   | 11. IF UNDER 24 HRS.                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Farmer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>Barton, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                      |
| 13. FATHER'S NAME<br><b>Henry Warnick</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Dawson</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |                                      |
| 17. INFORMANT<br><b>P.O. Box 599</b><br><b>Allegany County Infirmary Records</b>   |                                  | Address <b>Cumberland, Md.</b>  |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b><br>422.2 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Arteriosclerosis</b><br>(c) <b>Benign Hypertrophy Prostate</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b> |                                  |   |                                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that I attended the deceased from <b>7/8/59</b> , 19____, to <b>8/18/59</b> , 19____, that I last saw the deceased alive on <b>8/18/59</b> , 19____, and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>8/19/59</b>   |                                  |   |                                      |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.   |                                  | DATE SIGNED <b>8/19/59</b>  |                                      |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>   |                                  | Cumberland, Md.   |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>8/21/59</b>   |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow, Md.</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Eichhorn</b>   |                                  | ADDRESS<br><b>Lonaconing, Md.</b>   |                                      |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 24 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |                                      |

CERTIFICATE OF DEATH

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Allegany

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Allegany County Infirmary

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James William

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James William

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8642

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |   |   |   |  |  |  |
|--|---|--|---|---|---|--|--|--|
| MEDICAL CERTIFICATION  | 1. PLACE OF DEATH<br>a. COUNTY<br><b>Allegany</b><br><b>MARYLAND</b>  |  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br><b>Maryland</b><br><b>Allegany</b>                     |  |  |  |
|  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>           |  |   |   | c. LENGTH OF STAY IN 1b<br><b>60 years</b>  |  |  |  |
|  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>    |  |   |   | d. STREET ADDRESS<br><b>21 Prospect Square.</b>   |  |  |  |
|  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  |   |   |   |  |  |  |
|  | 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>William Patrick Warnick</b>                   |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>August 16 1959</b>   |  |  |  |
|  | 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3/1,-1899</b>                         |  |
|  | 9. AGE (In years last birthday) yrs.<br><b>60</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS.  |  |  |  |
|  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bartender</b> |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |  |
|  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |   |   |  |  |  |
|  | 13. FATHER'S NAME<br><b>William P. Warnick</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Frederick</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |  |   | 16. SOCIAL SECURITY NO.<br><b>220- 10-8699</b>  |   |  |  |  |
| INFORMANT<br><b>Wife Ada Warnick</b>   |   |  |   | Address<br><b>Same as Pt.</b>   |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure (Pulmonary Edema)</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CVA, probably a hemorrhage, right frontal lobe</b><br>DUE TO <b>CVAS</b><br>(c) <b>Arteriosclerotic &amp; Hypertensive CVD, with 3 prev./</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hours</b><br><b>4 days</b><br><b>3 years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |   |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |
| 20f. (City or town) (County) (State)   |   |  |   |   |   |  |  |  |
| 21. I certify that I attended the deceased from <b>August 13th, 1959</b> , to <b>August 16th, 1959</b> , that I last saw the deceased alive on <b>August 16th, 1959</b> , and that death occurred at <b>4:55 p.m.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>Algonquin Hotel</b><br>DATE SIGNED<br>ACTUAL SIGNATURE <b>Dr. W.F. Doerner, Jr.</b><br>PHYSICIAN'S NAME (Type) <b>Cumberland, Md.</b>   |   |  |   |   |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   |  |   | 22b. DATE THEREOF<br><b>8/19/59</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>     |  |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Maryland</b>  |   |  |   |   |   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b><br><b>Cumberland Maryland</b>  |   |  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 19 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                   |  |  |

**TO HOSPITAL OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# COMMUNICATOR OF DEATH

8648

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*[Handwritten signature]*

10/10/1918

10/10/1918

10/10/1918

10/10/1918



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

8643

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08627

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegheny</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>  |   |
| c. LENGTH OF STAY IN 1b <u>5 days</u>  |                               | d. STREET ADDRESS <u>33 N. Mechanic ST.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Mary Agnes Williams</u>   |                               | 4. DATE OF DEATH<br>Month Day Year<br><u>August 10 1959</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 17, 1878</u>                              |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |                               | 12. KIND OF BUSINESS OR INDUSTRY <u>—</u>  |   |
| 13. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>   |                               | 14. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>  |   |
| 15. FATHER'S NAME <u>Henry Sanders</u>   |                               | 16. MOTHER'S MAIDEN NAME <u>Katherine Malone</u>   |   |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>  |                               | 18. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>  |   |
| 19. INFORMANT <u>Mrs. Angela Pendergast</u>  |                               | Address <u>Cumberland, Md.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u><br>(c) <u>—</u><br>DUE TO<br>cause lost.   |                               |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3-4 days</u><br><u>-----</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip</u>  |                               |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell at home</u>                                      |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>7:00</u> p.m. <u>Aug. 4</u> 19 <u>59</u>   |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>   |                               | 20f. (City or town) (County) (State)<br><u>Cumberland, Alleg. Md.</u>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                               |  |   |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.   |                               | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>  |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>8/12/59</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jones Stein, Inc.</u>  |                               | ADDRESS <u>Cumberland, Md.</u>   |   |
| 24a. REC'D BY REGISTRAR <u>AUG 13 '59</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>  |   |

MEDICAL CERTIFICATION



8644

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY COUNTY</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND, MD.</b>  |   | c. LENGTH OF STAY IN 1b<br><b>17 DAYS</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL - MEMORIAL &amp; WARWICKS AVES.</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MINNIE</b> Middle <b>V.</b> Last <b>WINTERMOYER</b>   |   | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>21</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DECEMBER 29, 1898</b>                                |
| 9. AGE (In years last birthday)<br><b>60 yrs.</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>21</b> Hours <b>59</b> Min.   | 11. IF UNDER 24 HRS.<br>Months <b>5</b> Days <b>21</b> Hours <b>59</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE Mgr.</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hotel</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA, Artemas</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>IRVIN IMES</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>IMES, ELIZABETH</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>215-26-7557</b>  |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL - MEMORIAL &amp; WARICK AVES.</b>   |   | Address <b>CUMBERLAND, MD.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis involving</b><br><b>171X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>rt. pelvic wall. Carcinoma</b> DUE TO<br><b>cervix</b> (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Since June 1958</b> |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>7-16-1958</b> to <b>8-21-1959</b> , that I last saw the deceased alive on <b>8-21-1959</b> , and that death occurred at <b>5:35 PM</b> , from the causes and on the date stated above.   |   |  |   |
| ACTUAL SIGNATURE<br><b>W. F. Williams</b>   |   | DATE SIGNED<br><b>Aug. 22-59</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>W. F. WILLIAMS</b>  |   | ADDRESS (Street, city or town, state)<br><b>Cumberland, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>8-24-59</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |   | ADDRESS<br><b>Cumberland, Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>AUG 25 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |   |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

110528

CERTIFICATE OF DEATH

8642

ALLIANCE COUNTY, ILLINOIS

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

DECEASED, IN, 17 DAYS, CONSERVED, NO.

*[Faint, illegible handwritten text, likely a signature or official statement, covering the bottom half of the page.]*